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MALARIA.

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It seems that the profession is just now waking up to the subject of malaria; and certainly it is high time, for the reason that its influences, dire and insidious, have been working, mostly unrecognized, for all time past. That there is any more now than heretofore, except possibly in some localities, from special causes, I do not believe. It exists now exactly as it did in all the years past; no more and no less. But, thank fortune, the medical profession is beginning to study it with that care and diligence that will result in nothing but good to the human race, not only in its therapeutic management, but in the hygienic measures calculated for its diminution. That it existed many years ago, as now, the writer is able to prove by the fact that he instructed his students that if they would learn well the signs and symptoms of malaria in the human system, and its treatment, they could not fail in becoming good physicians, because a large share of disease ordinarily met with was either solely caused or to some greater or less extent influenced by its insidious yet recognizable workings; and I find in a published record of my own, about fifteen years ago, the following remarks written on the subject of "lumbago":

"Whatever the nature of malaria may be, it is certain that it inhabits the bodies of a large proportion of the population, especially in some

regions. It is also certain that it gives character to any disease that happens simultaneously to affect such a body, the same as syphilis, gout or lead does; that it sometimes, and often, so impresses a previous disease as to exercise a predominating influence, and must be neutralized before the disease can be cured; in fact, by so neutralizing it the disease of which it may be called a complication will yield of itself, or more properly speaking, by the powers of nature. To include this whole subject in one brief paper would, of course, be impossible. I may be allowed, therefore, to present some of the salient points involved, some of the more practical questions that are met with in our every-day experience, and leave the rest to be wrought out by our subsequent investigations. Surely our opportunities for observation are numerous, for everywhere the atmosphere is the ready bearer of this insidious poison. I say *everywhere*, because it is conceded that no region of any extent is altogether exempt. The north, south, east and west furnish vast fields for the easy generation of this subtle 'something;' and, indeed, it may probably be declared to be universal."

The writer's experience in the northern, western and southern States of this country enable him to express confidently such a belief. Twenty years ago, during our late rebellion, it is well known that in every part of the country which was occupied by our army our soldiers were severely affected by this cause. So much so that every disease and almost every injury was more or less influenced by it. Take a pneumonia, a dysentery, a typhoid fever or a bullet wound, and ten to one the call came, sooner or

later in the course of its treatment, for the free administration of remedies for malarial complications. Hertz utters this language, however, in the second volume of Ziemssen's *Cyclopædia*, which to me seems remarkable, viz: In England malaria is encountered but rarely, and is endemic only on the eastern coast and in some of the lowlands of the Thames," and adds, "Scotland and Ireland are free from it." I cannot but doubt the absolute correctness of this sweeping assertion, when over such an extended area the cause of miasmatic emanations, viz: decay of organized matter, must exist. However this may be, there can scarcely be a doubt that it exists, though much less concentrated, and hence not producing the severe but the milder effects in the human body, even in the countries included in this broad assertion. In further proof I will only add that Aitken and W. C. McLean, English writers on malarial diseases, mention no such immunity. The point I make in this part of my subject is that malarial influence is widespread, if not universal; and another point, that it existed for generations past precisely as it exists to-day.

A very important as well as practical question may be discussed at this point, namely, that of *mortality*. In this, as in many other medical questions, physicians disagree; some claiming that it often assumes a form that is speedily fatal, requiring only a few days' continuance to produce such a result; sweeping away the patient in a week or two. Others are of the opinion that ordinarily the poison of malaria is seldom fatal; that it may and does pervade the system for weeks and months, continuing its work but never increasing in intensity far enough to threaten life, unless the subject be in a particularly unfavorable state; even then only rendering it less resisting to the diseases already affecting it, and thus after a period, indirectly aiding the fatal result.

The writer, judging from his personal experience as well as the testimony of writers generally, is decidedly with the latter class in opinion, after watching with some degree of care the operation of miasma in the human economy, and continuing such observations in thousands of cases for the last thirty-seven years.

It is true that in the Pontine marshes, the Campagna of Rome, and some other similar localities fatal results may speedily supervene. Again, in other localities less pestiferous this toxic agent may induce complications capable of contributing to a fatal result; but ordinarily, and in a very large percentage of the cases, no such result is to be expected. Indeed, as a rule, it is

comparatively harmless, only as it slowly leads on to a cachexia or perverted state of the whole organism. Even if appearing as a complication of a particular disease, its power, when recognized, is almost always easily neutralized with appropriate treatment mingled with the treatment for the original disease. The fashion, therefore (for I fear it is becoming such at the present day), of ascribing malaria as a cause in our severe, or protracted, or fatal cases, should be very carefully considered in the light of truth, which is the only light of science. Few, I have charity to believe, are willing to pronounce such a verdict merely to cover up the want of a proper analysis of the case and the true cause of death. Such a diagnosis may be expected among the irregular and uneducated, not among the devotees of learning and science. The point, therefore, which I note here is that, while malarial disease and complications are very common, it is by no means to be charged with an evil agency in everything.

Having spoken thus openly, and perhaps strongly, on the question of accuracy in diagnosis, it will certainly be proper to indicate the principal symptoms by which we may distinguish the presence of this toxic agent in the human system. This I shall proceed to do willingly enough, yet not without the fear that my brief paper cannot contain all that should be noted on this very important point, for this is really the *fons et origo* of success in treatment.

From the days of Celsus, and perhaps far more remotely, it has been known that *periodicity* is a prominent symptom, one that when well marked is extremely valuable as a diagnostic sign. And further it may be expected to present itself, not only in purely malarial disease, but also more or less distinctly in others in which it forms a complication. True, it may at times be very indistinct; yet careful observation will rarely fail of detecting something of its presence as a modifier of symptoms producing an approach at least toward exacerbations.

Nevertheless, this feature taken alone cannot always be relied on, as is well known. Other diseases, unconnected with malarial poisoning, often present sets of symptoms involving those of periodicity. Notably is this the fact in most brain affections, when, if this symptom be taken alone, the physician may be misled. It will generally be observed in the earlier stages of tubercular meningitis, and it may be often noticed in the severe inflammations of the auditory apparatus, or the frontal sinuses, or the orbit.

In such cases it is evident that great caution is

to be exercised, as a full course of treatment for malaria, especially with quinine, would result in injury. Fortunately we have other equally prominent and corroborating symptoms, one of which is *intermissions*, or notable remissions.

This symptom, like the other, though especially useful and deserving of full consideration, cannot be relied on singly. However, the two taken together furnish valuable evidence.

The *variations of temperature*, as determined so accurately by that valuable little instrument, the fever thermometer, deserve particular attention, especially the character of the rise, which is particularly sudden, and also the very high degree of elevation generally attained, often, and unlike most other affections, reaching 104, 105, 106, or even higher, the first day, as well as in subsequent exacerbations.

Pain in the back is another symptom almost invariably present, generally severe, and voluntarily spoken of by the patient, most frequently occupying the lumbar region, sometimes the dorsal, and sometimes the entire length of the spine. The writer is invariably particular to inquire for this symptom, and considers it a strong diagnostic sign.

It will be observed that I have not spoken of *chills*, which symptom, although of the utmost value as a sign, is so common in other affections that, to be of real significance, we must wait for a repetition at a period subsequent to an intermission. One or two such repetitions occurring at regular periods can be accounted as positive or almost positive evidence of the presence of malaria. One peculiarity in regard to chills is that they are apt to continue for some time after the temperature begins to rise, and a still more notable peculiarity is that the patient is readily chilled nearly all the time, when he moves in bed or is exposed in any way; even during the intermission he frequently seeks a warm room or more clothing. This fact, I think, should be impressed, because it will often alone settle our diagnosis.

I will now speak of a symptom which I think of exceptional value, and which I do not remember as having been referred to by writers, namely, a *moist wrist*. This is scarcely ever absent, and when taken with even one or two other symptoms spoken of, I cannot but believe it to be almost pathognomonic. This moisture has a peculiar sticky feel, and when detected I scarcely feel required to ask the patient another question, because I can describe his case to him as well as he can to me.

But I must not omit to mention another symp-

tom, although my space is limited: A symptom, perhaps of all others the most significant, the most attracting in its meaning, the most reliable. I refer to *sweating*, or free perspiration during some part of each day. Gentlemen, the rule of my life has been to administer quinine in a very large percentage of the cases where this symptom was present, and it is present in our malarious region in many diseases not ordinarily considered malarious. I entertain no doubt, after an extended line of observation, that this rule may safely be followed, always excepting, of course, the cases that do not present a few, at least, of the other symptoms of the presence of malaria.

I am aware that this is a digression, but I have made it in order to more thoroughly impress the rule spoken of. Of course it requires the careful analysis of the careful physician; but it surely is worthy of attention.

A word or two may be spoken in regard to the tongue. It presents an appearance that is quite significant, but hard, if not impossible, to describe. This organ, taken as a whole, is slightly paler than natural, always moist, and evenly covered with a light colored, velvety coat. It is quite recognizable, and once seen always remembered.

A *cough*, sometimes severe, sometimes slight, generally accompanies malarial infection, and many such a cough cannot be broken up unless treated with anti-malarial remedies.

Having now mentioned some or most of the diagnostic symptoms (and this is all of this part of our subject we proposed to do) a brief recapitulation may not be out of place.

To enumerate, then, the symptoms as spoken of and in their order: We have periodicity, intermissions, extremes of temperature, pain in the back, chills, moist wrist, sweating, the peculiarity of the tongue and cough. These are mentioned in the order of their significance, except the perspiration, which is most to be relied on provided it be supported by a few, more or less, of the other symptoms.

It frequently happens that all the subjective symptoms are not present, yet two or more of them are generally sufficient, provided free perspiration, or at least a coolish, damp skin, appearing during some portions of each day, be one of them. With this, and the exclusion of possible exceptions already noted, we are tolerably safe in considering our diagnosis established, and in commencing proper anti-malarial treatment. However, in spite of all due caution, there will occur cases in which we have reason to feel a doubt. In such cases a few small, very small, trial doses, carefully watched, will settle the question on

one side or the other. The skin will begin to open and the intensity of the symptoms abate, or, on the other hand, the heat will be increased or the symptoms aggravated, or both, thus settling the question which before was conjecture.

Before proceeding to a very brief consideration of the treatment, I wish to call attention to a remark in the excellent work of Dr. Frederick L. Roberts on Practice of Medicine, with which I can scarcely agree, namely, that "young children are least subject to malaria." In my own practice I find many cases among children; fully equal to the ratio they bear to the population. Even young infants are by no means exempt, such being more subject than adults to aggravations of the cough named above as a diagnostic symptom. Many a little sufferer with labored breathing and severe cough is rapidly relieved with small doses of quinine.

It is not proposed in this paper to enter into a general discussion of the treatment, but to allude to only a few points.

A word may be spoken here in regard to drinking water, which, as is well known, is a common carrier of this and other poisons. For good reasons we have learned that wells and springs, especially the former, are common sources of malaria, because most of them contain percolations from the soil or surface of the ground, and of necessity the products of decaying matter. In our own city I find this especially true, and hence I am free to discourage the use of such water. Hydrant water is far preferable, and the reason why it is so, probably, is that it has more motion, more friction among its own particles, never lying so still and dormant as in wells. Why may not friction, constant agitation, destroy the spores, or whatever the substance is, of malarial poison? Large reservoirs for cities' supply, wherein the water lays dormant, never in activity only while flowing through the pipes, are not desirable. The smaller the reservoirs the better. The Holly system of water supply may and probably will be found preferable to others. Much might be said on this important subject, but time will not permit. I will merely give a case in point. A family consisting of four persons, by the name of Winterbottom, in our city, was taken with dysentery, only one of its members first. I found this and one other were particular to use the water from a well, not far away; the other two used hydrant water. In a somewhat jocular mood I said to the mother that I would assume to be a prophet! that those who used the well water would suffer most. The result proved my prediction true. The two who drank the well water

were very sick; one died. The other two had the disease, but in a much milder form.

I shall occupy my remaining time in speaking of the use of quinine and iodide of potassium as the principal remedies; and arsenic and eucalyptus globulus as remedies in the cachexia of malaria and quinia.

For more than two hundred years quinine has held the sway as the remedy *par excellence* in the treatment of malarial diseases and complications. Little need now be said in regard to it, after the researches of Binz, Bartholow, H. C. Wood and a host of others. In the mode of administration, however, there is some disagreement. Without giving the views of various writers, I wish simply to offer a point or two in my own experience. I find that I give almost invariably small doses; compared with the doses recommended by most others, they are *very* small. Seldom do the doses in my prescriptions exceed one half to two grains, and never, except in rare instances, is it found necessary to go beyond this amount; and during a general practice of many years this has been found amply sufficient. Indeed, ten to twenty grains, or even less, are, in the majority of instances, all that is desired for each case. I am unable to elucidate this, unless I am correct in the belief that in the administration of large doses much of it passes out of the stomach, and meeting with the natural alkalinity of the intestinal secretions, passes off unabsorbed and wasted. Even minute doses are often successful; and how can the fact be explained in any other way? It may, not therefore, be derogatory for a man with many gray hairs to recommend a careful consideration of this point. True, there are cases which require heroic doses, but in my experience they are few. Another explanation may possibly be, that I invariably administer the dose *every four hours*, never less or more. According to Bartholow, Binz and others, about five hours are required for the full effect of a dose to be reached, hence, to administer a dose, for instance, every two hours, or every eight hours, is folly, to say the least; the one exercises a cumulative influence, the other is partially lost. I wish to make every word a point in this matter, because, besides appearing reasonable, it has stood the careful test of many years.

Another point I cannot forbear alluding to is this: How long should quinine be administered to obtain its full anti-malarial effects? I answer forty-eight to seventy-two hours. At the end of this time all the good effects of the remedy may not be fully apparent, but I almost invariably stop its administration, and wait for the result, say twenty-

four hours, when it will generally be found to have accomplished its purpose. If not, it can be resumed for another like period. This is, however, seldom required. If it be not considered egotistical, I would make every word of this also a point for special consideration, being fully satisfied of its general truth.

Again, in regard to the long continuance of the use of quinine, something may properly be said. When this remedy is continued, even in moderate doses, say ten or twelve grains a day for several days, perhaps we may name one or two weeks, or often less, there begins in the patient what may properly be called *quinine cachexia*. The mere mention of this term, quinine cachexia, may convey a slight shock to the mind of the profession, and if so, I must face the responsibility, whatever the result. By the term I do not mean the fullness of the head, the ringing in the ears, the staggering gait, etc., produced by a few full doses, or by a single large dose, but the condition which may be called toxic, and characterized by a far different train of phenomena. These are, taken as a whole, very like the poisonous effects of malaria itself, that is, like intermitting fever. The symptoms of each are so similar that it is easy to be misled unless the history of the case be taken carefully into consideration, the quantity of quinine ingested, and the length of time it has been taken, etc. I have never seen its continued use fail of producing the state spoken of, and, indeed, such a condition has long been recognized. When it is once reached I am well convinced that quinia has lost much if not all of its salutary properties, and that the sooner its use is abandoned the better. The state for which it was rightfully administered, viz: the injurious presence of malaria, is fully remedied, generally speaking, and the toxic effects of the remedy substituted. With this belief I am convinced that many of the cases of the so-called "obstinate intermittents" are nothing more or less than quinine cachexia. I submit these studies to the careful and unprejudiced attention of the profession, in order that the truth or falsity of my position may be proved. The writer has met with many cases in point, which we cannot here relate, for want of time, and which were cured by simply withdrawing the quinine, and perhaps administering drop doses of Fowler's solution, and waiting a few days or weeks for the removal of the quinine saturation. For the same state iodide of potassium is an excellent remedy, given in small doses, or eucalyptus globulus either, for some length of time. The arsenic, in my experience, is generally preferable.

To avoid the cachexia, I am in the habit of giving the quinine till its full effects are obtained, then continuing treatment with the iodide, if necessary. I believe it was first recommended by Dr. Nonodnitschanski, in the form of the clear tincture of iodine, administered in water, and its good effects have been tested and confirmed by others. See *Braithwaite's Retrospect*, part 88, page 225.

LACERATION OF CERVIX UTERI; ETIOLOGY, PREVENTIVE MEASURES, TREATMENT AND RESULTS.

Read before the Northern Medical Society of Phila.,

BY E. E. MONTGOMERY, M.D.

Our knowledge of the importance of this lesion and the operation for its relief comes from Emmet, though the lesion was given as a cause for sterility by Gardner, in 1856, in his work upon that subject.

Emmet performed his first operation in November, 1862; although he performed it a number of times in the next seven years, he published no account, until in February, 1869, when he read a paper before the New York County Medical Society, on the surgery of the cervix. In this publication he was preceded a few months by a paper from M. A. Pallen, describing practically the same operation, though unaware of Dr. Emmet's work.

The lesion and operation, however, made but little impression upon the general profession until a second paper by Dr. Emmet, in 1874. Since the latter date it has been extensively performed, and is now probably recognized as the most frequent gynecological lesion and the one most demanding relief.

Authors differ greatly as to its frequency. Emmet found it in 32.80 per cent. of the women who had borne children, applying to him for relief of uterine disorders. Goodell and Mundé 17 per cent.; Pallen 45 per cent. My investigations in the Philadelphia Hospital lead me to believe that in nearly every primipara the cervix is fissured to a greater or less depth. That under favorable circumstances, where the fissure is slight and the vagina kept clean, the greater number heal without deleterious influences, but many continue unclosed, to aggravate and render miserable the future of the patient.

As to the site of the lesion, Pallen found that out of every one hundred cases 80 would present a tear upon the left side, 15 bilateral, and 5 upon the right. Emmet also found it upon the left side most frequently. Goode l, in one hun-

dred and thirteen cases, found the tear bilateral in ninety. In forty cases in which I have noted the seat of lesion, twenty-six were bilateral, with, in the majority of cases, the deeper cleft upon the left side, five of which presented a third posterior cleft, eleven presented a left-sided cleft alone, and three a right.

We can readily comprehend why the lesion should occur more frequently to the left, when we remember that the bi-mastoid diameter, in the greater number of labors, presents to the left side.

The frequency of the lesion is attributed to the use of forceps before the uterus is fully dilated, early rupture of membranes, failing to separate adherent membranes from the cervix.

One would naturally suppose that rapid labor would be an important factor in its production, but those having the largest experience have found it occurs almost entirely as a result of protracted labor. Rapid labor only occurs when the organs are in such a condition as to be able to properly discharge their functions. Any cause tending to protract the labor will increase the danger of producing this lesion, and hence may be considered a cause.

This subject has been well discussed by Pallen, in the *British Medical Journal* for the present year. In rapid contractions, where the placenta is attached at one side of the uterus, the muscular fibre being weakened at the site of implantation, causes a sigmoid wave of expulsive force directed away from the centre of the pelvic planes, or centre of the external os. As a result of this misdirected force, a segment of the cervix becomes folded over the advancing head, and becomes lacerated, because it is below the line of expulsive force. In such cases, the tearing begins within and extends toward the os; while ordinarily it begins at the os and tears toward the uterine tissue. It is likely to occur whenever, from any cause, as irregular pelvis or malposition of child, the symmetry of contractions be diverted into lines of expulsion away from the centre of exit, and the head be driven, anteriorly, posteriorly, or laterally, to form a capsule of the cervical segment, with production of perivascular ecchymosis, rupture of capillaries, oedema and bruising of tissue, by impinging against the pelvic walls. These conditions impair the elasticity and distensibility of the cervix. One of the most frequent causes is the scleremic state following inflammation or congestion, a result of the hyperplasia. In this condition the parts undergo shrinking, atrophy, and induration of the connective tissue, with agglutination of the muscular striæ, rendering

the whole substance hard, inelastic, and friable. Such a state renders the uterus slow to dilate, and it exhausts itself by repeated efforts at expulsion. The jamming of the enveloping segment against the pelvic walls bruises the already inelastic, non-distensible tissue, and increases the tendency to rupture. The osseous structures too small, or the child's head too large, deformities existing which render necessary the application of forceps, the dragging of the child through a bruised and exhausted cervix, necessarily causes tearing. It may also occur in version and head-last deliveries.

Even though the channels of exit be normal, but the uterus inert, from an excessive amount of liquor amnii, causing the power of the contractions to be lost, from being diffused over too large a surface, a failure of elasticity, or sort of paralysis, will ensue; and though the head be disengaged without accident, the shoulders are almost certain to produce laceration. Here, unless the accoucheur recognizes the condition, and by judicious and skillful management rapidly completes the labor, the accident is almost unavoidable. If, however, proper hydrostatic dilatation be followed by version or the use of the forceps, the labor would be terminated before paresis, oedema or ecchymosis ensued, and, consequently, save the woman serious injury.

When it does occur, nothing short of surgical skill rescues her from future ill health, or, perhaps, death from immediate hemorrhage or septic surgical fever. These lesions do not recover of themselves, though the majority of obstetric writers do not consider them of much importance. The laceration may, and frequently does, occur when the physician's hand is thrust into the uterus, in the operation of version. Emmet says it may result from criminal abortion.

How are we to determine that the lesion has occurred? We are not able positively to say it has occurred until after delivery. But in roomy pelves it may be suspected when there is a sudden bloody bathing of the vulva or child's head; also, when the head has been impinging against a hardened, inelastic cervix, and suddenly passes through it, as illustrated by the following case: Mrs. —, the wife of a physician, had suffered from uræmic symptoms for a week; was seen at 9 A. M., November 2d, 1880, when she complained of pains of an intermittent character which had distracted her rest the greater part of the night; the uterus was dilated to admit the finger; the vertex presented with the left occiput anterior. She was given a rectal injection of forty drops of tr. opii. During the day there was a bloody dis-

charge and severe pains, but os remained undilated. Given morphine sulph., gr. $\frac{1}{2}$, hypodermically. At 1 A.M., the os still undilated; at 4 A.M. was called to find child delivered. Her husband informed me there were but two or three expulsive pains. The child was quite small, feeble, and died the following day. Her health was very slow in becoming reestablished. A few months later the cervix was found to be lacerated bilaterally and through the posterior lip.

The symptom which causes us most strongly to suspect laceration is hemorrhage. If we find bleeding persists after the uterus has contracted, and the perineum and vestibule are untorn, we should make it a rule to assure ourselves by ocular inspection of the seat.

It is true, the finger will indicate the torn cervix, but should there be any doubt, there should be no hesitancy in placing her in a semi-prone position, retracting the perineum with Sim's speculum, cleansing the vagina of clots, and seeing the point from which the bleeding occurs. Supposing we find a rupture of the cervix; what is to be done?

Certainly good surgery would teach us to place the parts in such relation that the normal condition would be restored, and it becomes a question whether more than rest is needed to bring this about. In cases of slight laceration, union is probable, but when we remember the enlarged state of the organ, its subsequent process of involution, and that the wounded surfaces are constantly bathed with lochia, we are not surprised that in the majority of cases of severe rupture union does not take place.

The better plan would be that recommended and first practiced by M. A. Pallen, closing by wire sutures. All the conditions are favorable to its immediate performance—the vagina and vulva well dilated, the uterus easily drawn down. The sutures should be introduced and brought out a full half inch or more from the margin of the rent, remembering that we are dealing with greatly exaggerated tissue, which rapidly undergoes a retrograde process and consequently requires a deeper hold. The sutures should be twisted and cut half an inch long. The parts should be carefully watched subsequently, and if any of the wires show indications of becoming loose, they should be tightened by twisting. The sutures may remain two weeks. An antiseptic injection should be used several times daily during convalescence.

The advantages in performing the operation at once are, that it arrests hemorrhage, decreases the danger of septic fever, promotes involution,

precludes the necessity of a secondary operation, and saves the patient a life of invalidism and the expense of future treatment.

When a deep laceration is allowed to remain unstitched, it will sometimes become closed, but more frequently union fails to take place. As a result of the fractured surface, or possibly the absorption of septic matter, a sort of paralysis of the capillaries occurs; the process of involution is arrested, the uterus remains large, its weight causes it to settle further down in the vagina, or possibly become retroverted, increasing the derangement of circulation. The traction upon the lips by the vagina separates them and is still further increased by pressure upon the posterior vaginal wall or floor of the pelvis. The constant motion to which the organ is subject, in respiration and exercise, breaks the granulations and keeps up the irritation.

When a woman who has had one or more children complains of leucorrhœa, menorrhagia, of greater or less degree, intercostal neuralgia, hemicrania, pains in either iliac fossa or in the back, with vesical or rectal symptoms, we have a cervical lesion, and as this is the most frequent lesion—of the cervix—in the mother, we are justified in suspecting its existence, particularly when the abdomen is free from tenderness. We can only arrive at a certain diagnosis, however, by an examination.

The convalescence of such a patient may be much retarded, having what is known as "a slow getting up," suffering at once from the symptoms we have enumerated. Others enjoy good health until lactation ceases, and the ovaries reassert themselves, when the woman finds herself an invalid.

Menorrhagia, though frequent, is not a constant symptom. In some cases the menstrual flow is diminished, and may even be absent. The cervix is found patulous, so that the finger readily enters the canal. The surfaces may be simply abraded, inflamed, angry looking, lying in contact, or widely separated, the lips hard, from inflammatory exudation, the mucous membrane everted, studded with mucous cysts and covered with granulations, or the clefts have healed over, and are the seat of cicatricial deposits.

It is sometimes difficult to determine the presence of laceration. The clefts may be completely filled with hard, dense tissue, having the feel of cartilage, the cervix larger at the extremity than above, and with its antero-posterior diameter greatly increased. Others are seen with

the cervix greatly hypertrophied, dense, covered with exuberant granulations, that bleed upon the slightest touch. Such a case may be readily mistaken for cancer.

In the spring of 1879 I was called to see Mrs. S., aged about 40, who had suffered from uterine disorder for some months; for the last three weeks she had had a continuous bloody discharge and shooting pains through the pelvis. She had lost flesh and appetite; the uterus was nodular, covered with exuberant, easily broken granulations, that bled when touched. The discharge was attended with an offensive odor. I had but little hesitancy in pronouncing it a malignant condition. Imagine my surprise, then, when it healed completely under applications of chromic acid alternated with glycerole of tannin, and disclosed five clefts.

The vaginal portion of the cervix has much to do with the maintenance of the uterus in its relative position to the other pelvic organs. Any laceration must increase the tendency to displacement. Retroversion is probably the most frequent. A peculiar form of ante flexion is sometimes seen confined to the anterior segment, which is hypertrophied and elongated, while the posterior is normal in size, or atrophied. If the laceration be one sided there is less eversion of the mucous membrane, but the uterus resting upon a sort of tripod, as the torn surfaces separate, produces a partial obliquity, by crowding the cervix to the uninjured side. Cellulitis has a similar effect by shortening the broad ligament.

Cellulitis is the most frequent complication, and is almost sure to occur when the lesion extends above the vaginal portion. Slight anterior and posterior lacerations are of but little significance, as there is but slight tendency to separation. They usually heal during convalescence, but a deep anterior sometimes extends into the bladder. The vaginal portion may close, leaving a vesico-uterine fistula.

These cases were formerly treated by caustics, as nitrate of silver, caustic potash, and the acids; by the application of the actual cautery, or amputation of the cervix; methods of treatment that resulted in the increase of cicatricial tissue and aggravated the reflex symptoms by the pressure upon the terminal fibres of the uterine nerves. The object of treatment should be, as far as possible, the restoration of the normal condition. This can only be done by freshening the surfaces and keeping them in apposition.

Some preparatory treatment is frequently necessary, particularly where there are evidences

of former cellulitis or pelvic peritonitis, present inflammation of the cervix, or extensive eversion of the mucous membrane with cystic degeneration. Emmet expressly states the necessity of postponing the operation until all acute inflammatory symptoms are removed. The operation should not be done after a cellulitis or peritonitis, so long as any tenderness is present.

In performing the operation the patient is usually placed upon her left side, and the perineum retracted with a Sims speculum. Where the uterus is very movable, and vagina large, it may be done with the patient upon her back; the uterus is drawn down by a tenaculum, or volsella forceps, and transfixed from before backward by a curved needle bearing a strong silk thread. This thread is hooked down from the cervical canal, cut, and the ends tied, giving a handle for each lip. The tourniquet is now applied well above the lacerated surfaces. It may consist of a watch-spring arrangement, as used by Dr. Emmet, an ordinary wire ecraseur, or a flexible metal catheter with the end removed and a strong loop of thread passed through it, which is placed over the cervix and drawn tight, the ends tied around the rings of the catheter. I use the tourniquet in all cases, as it renders the operation bloodless, hence more agreeable and expeditious. The surfaces are now separated, and in a double tear freshened on each side, from one lip to the other, leaving a strip of mucous membrane in the centre of each, which forms the future cervical canal. This undenuded portion on each lip should correspond with that upon the opposite, and should widen toward the extremity, so as to present a trumpet shape. Great care must be observed in denudation, to remove all cicatricial tissue from the angle of the cleft. Should a wedge-shaped piece be allowed to remain, greater traction is made upon the sutures when the parts are approximated, and this mass, by pressure, arrests the circulation. Should union take place, its pressure upon the nerves included in its structure may cause reflex neuralgia.

In cases of long standing, where there is much cystic degeneration, and the lips are hypertrophied, everted, and convex, it is necessary to remove a large portion of tissue, so that the edges may be properly turned in. The cervix is sometimes lacerated in three or four places; were we to freshen each cleft, and bring them together separately, the result would most probably be failure, as the traction in opposite directions would cause the sutures to cut out. It is better to join two clefts by removing the segment between them.

In drawing down the uterus we must be governed by its movability. The lower surface should be freshened first, as then it will not be obscured by blood running over it. The portion to be removed is hooked up by a small tenaculum and kept on the stretch while it is being removed, which should be done by a single strip from one lip to the other. The denudation may be done with either scissors or scalpel. With either the surfaces should be made perfectly smooth and uniform in extent, the object being to bring about union by the first intention, as any granulation must result in cicatricial tissue.

In old cases the introduction of sutures is often quite difficult. The best needle for this purpose is one about an inch in length, slightly curved at the point and beveled at one side. It should be threaded with a silk loop held by a half knot. The wire suture is hooked into this loop. The first suture is introduced near the angle of the cleft; the others three lines apart, entered and brought out three lines from the margin of the freshened surfaces. The parts are cleared of foreign substances and the sutures twisted, observing care to have the freshened surfaces well covered or turned in. The sutures, cut an inch long and turned back, will give no trouble. They may be secured by shot, but are more likely to cut, leaving a ragged surface; also, more difficult to remove.

The patient should be kept in a recumbent position for two weeks. The bowels need not be constipated but should be evacuated and the urine voided upon a bed pan. After micturition a few syringefuls of warm water should be thrown into the vagina, to dilute any urine that may have passed into it. Antiseptic injections should be used daily after the first forty-eight hours. The sutures are generally removed on the seventh or eighth day, and care should be exercised not to separate the surfaces.

The patient is placed upon her left side, the cervix brought into view by Sims' speculum, the lower portion of the loop cut, and traction made downward. In this way the loop binds together the parts until it is completely withdrawn; if cut above it would separate them.

She should remain in bed a full week subsequent to the removal of the sutures. This rest promotes the union, prevents the danger of cellulitis, and helps decrease the size of the uterus.

It is necessary to exercise some caution as to what result we promise our patient; for this operation, though not a serious one, is not absolutely free from danger. Emmet has lost two cases, Dr. Hunter, of New York, one; they died

from cellulitis or peritonitis. It does not always afford the relief we expect from it. It has been my own experience to have a patient suffer just as severely after a successful operation as before, much to our mutual disgust. We can, however, in all uncomplicated cases, promise complete relief. In cases of retroflexion and version it would be necessary to follow the operation by the use of a pessary, the comfortable use of which the operation greatly promotes.

It is often asked, "What effect will the operation have upon subsequent parturition?" If the cicatricial tissue is completely removed, and union secured by first intention, I cannot see why there should be any difficulty.

The last number of the *American Journal of Obstetrics* reports eight cases in which labor subsequent to the operation had not been attended by laceration.

HOSPITAL REPORTS.

MEDICO-CHIRURGICAL COLLEGE.

SERVICE OF F. LE SIEURE WEIR, M.D.,
Clinical Professor of Dermatology.

(Reported by DR. H. B. NIGHTINGALE, Chief of Clinic.)

GENTLEMEN:—Our clinical material being unusually abundant to-day, I shall have the opportunity of showing you cases illustrating several varieties of skin disease which I had occasion to mention in recent didactic lectures. Most of the cases are such as are met with constantly, and such being the case it behooves you to be familiar with them. The first case, which will now be brought in, is somewhat more extensive than is usually seen, and will give you an excellent idea of the disease.

Syphiloderma (tuberculosum).

CASE 1.—This woman is an American, married, and 33 years of age. She tells us she was perfectly healthy up to five years ago, at which time she had been married to her present husband for one year, he being her second. At the time mentioned she noticed a small spot upon the forehead, which quickly pustulated. It was very persistent, and at last she thought to try the effect of inoculating herself elsewhere with the pus, to "see what it would do." She found out; and in doing so unconsciously settled the diagnosis. The place chosen was the shoulder, directly over the acromion process. The inoculated spot shortly gave rise to similar ones, all in the immediate locality. These tubercles, for such they are, have been present ever since, occasionally dying away for a few weeks. You here see the full-blown tubercles, while near them are others in their very incipency; and somewhat removed are the old cicatrices. Each is coppery in color at the base, with intermingled erythema. The case is plainly syphilitic in nature. If more evidence is wanted to prove this, I may mention the presence of nocturnal pains in the bones, marked alopecia, sore gums, and a generally degen-

erated system. There is no history obtainable of a primary sore at any time. The tubercles are, as you see, covered over in part by dark scabs, and have a hard, inflamed base. Can we do anything for this? Certainly we can. To begin with, we will give her five grains of potassium iodide, with one twenty-fourth of a grain of corrosive sublimate, in half an ounce of cinnamon water, three times a day, after meals. She will take this for, say two weeks, after which she will be put on one-quarter grain doses of the proto-iodide of mercury, taken thrice daily, in pill. A proper interval, however, must be allowed between the two medicines, for when they are given together biniodide and metallic mercury are the result. Locally, an ointment composed of ung. hydrg. nit., $\mathfrak{z}\text{ij}$ to ung. petrolei, $\mathfrak{z}\text{v}$, will be used about twice daily. This will be followed by a soothing ointment of benzoated oxide of zinc, containing a few drops of carbolic acid. Good results may be expected from this, and if we could keep her long enough she would obtain permanent relief; but, like all such patients, as soon as the sores heal she will leave us.

Psoriasis.

CASE 2.—Miss C., American, 22 years of age. This young lady has been sent here by a medical gentleman, for advice. The case shows us a number of white or pearl colored patches, situated mostly in the neighborhood of the joints, and having a tendency to extend downward toward the hands and feet. It is quite thick here about the elbow, and being well marked, you can see the scales piled up, one above another. I would like you to observe the shape of the patches, it being one means of determining the variety of psoriasis, for that is the disease; and also the size, as another point of diagnosis. The patient states that she has had the difficulty since childhood, but that during the summer months it nearly disappears. There is no itching to speak of. Her general health is good, and the menstrual functions are performed normally, while the stomach, notwithstanding the pouring down of a good deal of medicine, remains in good condition.

We have made out the disease but not the variety. Of the latter there are a great many—far more, in fact, than there is any use for—and they greatly confuse the student. I will refer you to the text books for their description, and only mention the variety known as *nummularis*, under which this case is classed. It is so named from the patches being about the size and shape of a coin. In the present case they are about the size of a half dollar. It is a disease utterly devoid of discharge of any kind, and is, therefore, properly classed under the squamous group. Pathologically, psoriasis, otherwise known as *lepra vulgaris*, consists of hyperæmia of the cutis, together with hypertrophy of the papillæ and excessive cell proliferation.

The patient being of a lymphatic temperament, as are a majority of the subjects of the affection, we will place her on cod-liver oil, giving a dessertspoonful three times daily, after meals, in emulsion. The Doctor has tried chrysophanic acid with a negative result. After awhile arsenic may be given here to advantage, I think, and the most desirable form is the solid, inasmuch

as Fowler's solution is too varying in strength. Locally the treatment must be judicious, for harm may easily be wrought, owing to the sensitiveness of the skin, more especially in the young. She shall be ordered a bath every night, in which from two to four ounces of sodium bicarbonate are dissolved. After remaining in for not over ten or fifteen minutes she shall be dried and thoroughly anointed with olive oil or cosmoline. This will result in softening the skin and loosening the scales. Until the scales are got rid of, no direct medication will be used, for it would not reach the seat of the disease. I think we may venture upon slight stimulation then, and will, therefore, advise the Doctor to use something like the following:—

R.	Ung. hydrarg. nit.,	$\mathfrak{z}\text{ij}$	
	Ung. petrolei.,	$\mathfrak{z}\text{j}$	
	Ol. olivæ,	$\mathfrak{f}\mathfrak{z}\text{ iiss}$	
	Ol. cad.,	$\mathfrak{f}\mathfrak{z}\text{j}$	M.
	Ft. ung.		

Sig.—Apply twice daily.

Ecsema.

CASE 3.—This man, D. M. aged 70 years, Irish by birth, is also sent by a physician. He has had an eczema of the palmar surface of the hands for about eight months, and if you examine, you will see that extending in numerous directions are large cracks, which bleed when irritated by the movements of the muscles. Surrounding the cracks the epidermis is engorged, but evidently he is much better than he was some weeks or months ago. The man's occupation is that of a dyer, and the contact of the parts with the various dyes has given rise to the disease. There are present all the symptoms which ordinarily accompany this affection, such as itching, burning, etc., together with moisture, though the latter is not very prominent now, except in the immediate neighborhood of the fissures. The presence of the fissures determines the variety, and we therefore call it *eczema fissum*. No treatment other than for the cracks is desired, as it is doing well enough otherwise. We will, therefore, apply pure carbolic acid to the sides of the fissures, by means of a smooth piece of wood, and ask the Doctor to repeat this once or twice, weekly, as long as necessary. A very few will suffice, however. In addition, he shall have an ointment composed of—

R.	Hydrarg. chl. mit.,	$\mathfrak{z}\text{ss}$
	Ung. picis.,	$\mathfrak{z}\text{ij}$
	Ung. petrolei,	$\mathfrak{z}\text{ss}$

Sycosis.

CASE 4.—A. H., aged 30 years. This young man presents himself here to day with the state of affairs which you here see. The whole surface wherever there is beard is hot, red, swollen and tense, with pustules in abundance. He has persistently shaved the parts, which has only made matters worse. Each pustule is pierced by a hair, and this is to be borne in mind, for it is one of the diagnostic points. His occupation is that of an engineer, and the sudden transition from the hot air of the engine room to the cold air without has probably been the cause. This is strengthened by his evidently anæmic condi-

tion. How do we distinguish between this affection, known as sycosis, and the parasitic affection of the same name? In a recent didactic lecture I told you that it were better to call simple inflammation of the hair follicles sycosis, and a similar disease, caused by a vegetable parasite, tinea sycosis. The latter is the only disease with which it is liable to be confounded, and it shows us the eruption occurring at points not covered by hair; it does not affect the upper lip; and lastly, by means of the microscope we can detect the fungus. In the present case you see that the upper lip has not escaped, that each pustule in this situation is pierced by a hair, this being the only unshaven part. We will first give him a saline aperient and put him on tincture ferri chlor. in fifteen drop doses three times daily, in water. Locally, warm poulticing, followed by a soothing ointment of oxide of zinc or a lotion of lead water and laudanum. I do not much like the plan of laying open the pustules and tubercles, unless the case is a very severe one and does not take kindly to medication. The case before us is not one for an operation of this kind. He will be directed to let his beard grow, but keep it clipped close. Epilation does harm in these cases.

Herpes Zoster.

CASE 5.—J. S., aged 6 years. This little boy is brought to us by his mother, who wants to know what is the matter with his side. Upon examination we find a small number of minute vesicles seated upon a somewhat inflamed base, and involving not quite one-half the body from the spinal column to the median line. The vesicles here follow the course of the cutaneous nerves, which is one of the peculiarities of the disease. It is a case of shingles, or herpes zoster. Being a simple case it needs no special treatment. We will simply give him a dusting powder of subnitrate of bismuth or oleate of zinc, and have his mother protect the parts from contact with the clothing by a piece of soft muslin. He will be well in a few days.

Tinea Versicolor.

CASE 6.—W. G., aged 17 years. This young man has an affection of the skin which is very instructive. The whole front of the body is covered with brownish yellow staining, apparently from the neck to the pubis, and the back is not much better. The discoloration also extends down the arms as far as the hands, where it takes on the appearance of little erythematous points or spots. By passing the finger over the surface you see that it is uneven and rough, and that the parts have a greasy feel. The disease has existed for two years, and first began as a small yellow spot at the epigastrium, which gradually spread until it has assumed the proportions which you now see. He says that it itches very much, and that when warm in bed this is worse. No doubt it is.

It is a case of tinea versicolor, or chloasma, as it was formerly called. It is due to the presence and growth of a vegetable parasite upon the epidermis, known as the *microsporon furfurans*. There is no danger of contagion, for its activity in this respect is very feeble. The copper color

of the syphiloderm is the only disease liable to be confounded with it, and there you have the history, with, also, the long train of symptoms invariably to be met with.

He will be directed to cleanse the parts thoroughly, twice a week, with soft soap and water, after which he will apply freely, twice daily, a lotion containing from 30 to 60 grains of hyposulphite of soda to the ounce of water. After the plant is removed the lotion should still be used for a week or two, for, although apparently cured then, it will be liable to relapse. Three or four weeks ought to effect a cure.

MEDICAL SOCIETIES.

NORTHERN MEDICAL SOCIETY OF PHILADELPHIA.

Dr. Montgomery read a paper upon Laceration of the Cervix Uteri (for which see page 453.)

Dr. Croasdale asked if there was not difficulty in bringing the surfaces together when operating with the use of the tourniquet.

Dr. Beates asked what were the indications for an operation, stating that he had operated in one case of uterine megrium in which the union was complete, yet with no relief of the megrium. He stated that seventy per cent. of such cases that had been operated upon had failed to relieve this symptom. He would operate if there was menorrhagia even in a slight degree; also, in case of granular degeneration that returned after scraping. He had seen four or five cases out of twenty-five or thirty in which he would not operate. In performing the operation, he placed the stitches as near the surface as possible, including only about one-fifteenth of an inch between the wires, believing that deeper ones were more liable to cut through and loosen. He uses shot and draws them loosely; removes the sutures after nine days; has never had a failure to unite.

Dr. Hall asked if there was any account taken of the menstrual period in selecting the time for operation; also, an explanation of several fissures being found. One rupture, or, at most, two lateral ones, would relieve the strain and allow the head to pass, thus satisfying all the mechanical difficulties and precluding any more.

Dr. Collins said he had not met with an actual case of tearing of the os uteri during labor, and asked for the experience of the other obstetricians present. In performing the operation for relief he had never used the tourniquet.

Dr. Eskridge thought that these cases must be the ones referred to by the older gynecologists under the name of ulcer of the womb. The condition of ulcer he thought very rare, and mentioned that out of two hundred cases examined in one year at the Catharine Street Dispensary, not one of ulcer was found.

Dr. Walker would advise the use of the tourniquet; he had operated without and had been with Dr. Montgomery when it was used. There was a saving of some blood, greater cleanliness, and the surgeon felt in less haste. He thought there was some danger of a thrombus, but there is no record of one having been swept into the general circulation. He had seen Dr. Duer

operate with the patient placed upon the back, which required two assistants, one to support each limb; at the same time it allowed the operator to sit in a comfortable position.

Dr. Montgomery, in reply to the several gentlemen, said that he could see no danger of thrombus, as the tourniquet was not tight enough for that. The supine could have no advantage over the ordinary position of Sims, since he could be seated with the patient in either position. Regarding the time for operating, he made the interval as long as possible before the return of the menses—could usually obtain three weeks. He thought the os might be ruptured in several places at a single labor, but that multiple fissures were usually the result of several labors. He thought it important to emphasize the point of delaying the operation until all tenderness of the womb had disappeared, as one or two lives had been lost from neglect of this precaution. The ease of the diagnosis he thought to depend upon the kind of speculum used; that of Sims being the best. He had met with no difficulty in approximating the parts while using the tourniquet.

Dr. Collins exhibited some specimens of for-

sign bodies removed. 1st, a bit of wood, 2½ inches long, ¼ inch in diameter, taken from the index finger of a boy who had his hand mashed. The stick was partly broken opposite the joint of the finger, so as to allow its motion. The patient was unaware of its presence. 2d, a cigarette holder 2½ inches long, ⅜ of an inch in diameter, removed from the urethra of a young man who had inserted it during a debauch, two days previously. 3d, a feather, 2 inches long, ¼ of an inch wide, expelled from the mouth during a fit of coughing. The patient was subject to a spasmodic cough, which was not relieved by the usual remedies. He had during the treatment examined the throat very carefully with the laryngoscope, and on one occasion saw as far down as the bifurcation of the trachea, without discovering anything wrong. 4th, several small calcareous bodies, ⅜ of an inch in diameter, coughed up. The patient had been subject to cough for several months; was not relieved until after the expulsion of these bodies. He had examined the lungs several times, but never could detect anything wrong in either.

The calcareous bodies were referred to the committee on morbid growths.

EDITORIAL DEPARTMENT.

PERISCOPE.

Puerperal Convulsions.

At a recent meeting of the Dublin Obstetrical Society (*Dublin Journal Medical Science*) Dr. Richard Henry presented four cases of labor complicated by convulsions. After reading histories of the cases, he said: "In these four cases the distinction between true epilepsy and epileptiform convulsions is well marked, the fit in the former not returning except at the distant intervals the patient is accustomed to, and being no hindrance to recovery. In fact, no particular importance was attached to the fits in the first and fourth cases, once their true nature was apparent. Again, in the second and third cases there is marked distinction. In the second, the anasarca was general, invading the face, arms and legs, while in the third case it was confined to the ankles. In the second case the fits commenced before labor was concluded, and in the third when it was practically at an end. The second was infinitely more serious, and the question suggests itself whether the greater amount of uræmia not only brought on the fits before labor ended, but also increased their number and severity after it was concluded. The number of the fits (seven teen), the profound unconsciousness, the obstinacy of the bowels, and the good results following the old-fashioned practice of bleeding, and, above all, the complete recovery of the patient, are features worthy of note. Again, the question arises, does the bleeding, by speedily lessening the amount of uræmia, and by emptying the blood vessels rapidly, permit the resumption of

nervous energy or tone of both cerebral and sympathetic nerves, as shown by quickly returning consciousness on the one hand, and on the other, by the satisfactory motions from the bowels, as both systems seemed profoundly paralyzed by the poison? Also, are there not plethoric cases in whom convulsions might be more speedily cut short, and more safely also, by bleeding than by any newer method? I remember a case some years ago, where the patient was bled to forty ounces before the fits ceased; no chloroform was used and she made a good recovery. Dr. Kidd, in discussion said: The fourth case is interesting, as showing that epilepsy occurring during labor is not such a very serious affection as uræmic convulsions. That point is very conclusively established by the paper. I have myself resorted to bleeding, but not with the good results recorded by Dr. Henry. Purging is the remedy on which I chiefly rely. It is often very difficult to get the bowels to act, and in several cases in the Coombe Hospital we have not hesitated to give 20 grains of calomel, and even to add to it some croton oil. The best of our recent observers have noted the good effects of large doses of calomel in cases of uræmia from kidney disease.

Dr. More Madden said: "It appears to me impossible to discuss together with any advantage the general treatment of diseases so essentially distinct as the different forms of puerperal convulsions of which Dr. Henry's paper furnishes us with examples. For instance, the hysterical form of the disease is one requiring little or no treatment of any kind, whereas epileptiform puerperal convulsions, whether uræmic

or not, always require the most active prophylactic and remedial treatment. Still more essential is such treatment in the sthenic or apoplectic variety of puerperal convulsions, which may be either merely a later stage and more profound degree of the last named form, or may assume its distinct apoplectic character *ab initio*. Of the value of large purgation, counter-irritation, and cold effusion in such cases, there can be no question. As to chloroform, all the benefit I have seen from its use was to allay for the time the convulsions, and thus aid in gaining time to effect delivery, which must always be a primary consideration in the treatment of these cases. As to chloral and the many remedies which I have seen tried, all I can say is, that in any grave case of true puerperal convulsions time is far too precious to be wasted in trying experiments with such doubtful agents when life is hanging in the scale. In such cases, and I now speak of sthenic or apoplectic convulsions, bleeding is the only reliable remedy, and I have no doubt that to save the life of a plethoric patient we must still bleed as freely as our ancestors did a hundred years ago, or else the patient will die, as such patients did during the interval of time when bleeding was driven as completely out of midwifery as it was out of every other branch of medical practice."

Dr. Purefoy said: "I have seen a good many cases of puerperal convulsions, and the only case of recovery was one in which the woman was freely bled. I saw a case of a primipara in puerperal convulsions which appeared perfectly hopeless; she was saved by free bleeding."

Dr. Atthill said: "I have been in the habit of bleeding occasionally in convulsions, and have never seen it do harm. Sometimes it seemed to do no good, while, on several occasions, I have seen excellent results follow. Chloroform sometimes stops convulsions; it frequently retards them, but it is not curative. Chloroform is only an expedient to procure the cessation of convulsions till the other treatment acts."

The Chairman concluded the discussion by saying: "I think we ought to keep the different forms of convulsions separate in treatment. The treatment of ordinary uræmic puerperal convulsions is, I think, much the same as of convulsions occurring in Bright's disease. That apoplectic convulsions which depend on anything like effusion into the brain ought to be treated according to the ordinary principles for the treatment of apoplexy, is also, I think, obvious. Uræmic convulsions may, by causing increased tension of the blood vessels of the brain, lead to rupture and consequent apoplectic convulsions; and one object of treatment should, therefore, be to quiet the convulsions. Bleeding lessens the tension; but, on the other hand, it renders the blood more watery, and so increases the probability of the convulsions being repeated. It is obvious, therefore, that all forms of puerperal convulsions cannot be classed together as though they depended on the same cause. Morphia is used to prevent a convulsion taking place. As regards curative treatment, we should separate convulsions occurring before, during, and after labor. As long as there is a child in the uterus, our efforts should be principally directed to removing it; and until

that is done it would, I think, be premature to bleed the woman."

Rupture of Bladder.

In the *Lancet*, Dr. Padley records the following case: Towards the end of last June I was called to see Mr. J. S., who had a short time previously consulted me for a syphilitic perforating ulcer of the soft palate. He was suffering from most intense pain in the abdomen, a little above the pubes, attended by sharp rigors and vomiting, and other symptoms of severe pyrexia, which recurred intermittently from time to time. There was no distention in this region, but some induration and redness and subsequent swelling. The pain, though relieved by opiates, fomentations, etc., continued very acute, and the redness and induration spread rapidly over the abdomen toward the left side. The case was one of severe and extensive phlegmonous erysipelas. There were rapid suppuration and sloughing of the parts, into which I made a free incision, and through which a large quantity of ichorous, offensive discharge freely escaped. Notwithstanding this, the disease spread up the side of the abdomen and chest nearly to the axilla, near which and in the intermediate space other incisions were made and drainage-tubes introduced, the wounds being dressed with carbolic acid lotion. The greatest portion of the subcutaneous areolar tissue of the region, however, sloughed, and had to be removed as it became sufficiently detached. The discharge was immense, and the constitutional symptoms, as may be supposed, were of a very grave character. A few days before my return home, after a short absence, while the patient was straining to empty the bladder, a gush of fluid, "about a tumblerful," suddenly spouted out in a free stream from the wound above the pubes. The urine, for such the fluid proved to be, continued for some weeks to be freely discharged through the orifice, and a little continued to escape occasionally, sometimes at long intervals, when there was more than the usual obstruction to its flow through the urethra, as from mucus, etc., until within a few weeks of his leaving this neighborhood. After the sloughs were detached, the extensive chasms left granulated favorably and cicatrized, a sinus evidently remaining in communication with the bladder, and the patient completely and rapidly recovered his health and strength. An attack of acute pneumonia threw him back for a time, but from this he also made a favorable recovery.

In reply to my earlier inquiries, he at first stated that he had had but little difficulty in emptying the bladder, though the stream of urine was rather small and required more effort to void than formerly, yet not more than had been the case for a long time previously, the bladder being fairly emptied and the urine generally clear. On passing an instrument, however, I found a very close stricture extending through the greatest portion of the canal—at first admitting only a filiform, and afterwards a No. 1, bougie—which no doubt caused greater difficulty in micturition than he admitted, owing, as he afterwards confessed, to his dread of instruments, having formerly suffered much from their use. There

was, he affirmed, never sufficient retention to cause him much inconvenience, and I never found the bladder distended. Up to this attack no pain in this region was complained of.

Such being the facts of the case, what was the immediate cause of the rupture and the discharge of urine? There were, of course, two factors in operation: the sloughing of the abdominal wall and the straining efforts in micturition. Did the perforation of the bladder and consequent extravasation of urine into the abdominal areolar tissue take place in the first instance and set up the cellulitis and sloughing, which afterwards led to the free escape of urine, the pelvic cavity having been protected, and further extravasation prevented, by adhesions around the orifice, a fistulous opening being thus formed? Or were the cellulitis and its consequences, arising from other causes, the primary condition? There can, I think, be little doubt that the first view is the correct one. If so, what caused the rupture? Was it the result of (1) distention and straining, the mucous coat of the bladder having, perhaps, become sacculated and thinned, or even having formed a hernia through the muscular coat, due to the daily repeated efforts to empty the viscus through so small a channel, extending over a very long period of time, and, under a final effort, giving way? or (2) a chronic ulcer leading to perforation under similar conditions? The facts that the patient had at no period suffered any inconvenience from distention of the bladder, and that when I was first called to see him there was no evidence whatever of any such distention, preclude, I think, the former idea; besides which there is, as far as I am aware, no recorded instance of the bladder having been ruptured above the pubes by the mere straining efforts of micturition unaccompanied by some kind of violence. In the only two cases quoted in the leading article, where this accident appears to have been caused by violent action of the abdominal muscles, the rent was found in the back part of the bladder, and in distention from stricture of the urethra the membranous portion of that canal usually first gives way. Besides a case of Mr. Harrison's, referred to in the article, an instance has been recently given by Dr. Call (*Lancet*, Dec. 10th), in which rupture from the latter cause must have occurred in the lower and back part of the bladder, the gush of urine having taken place through the anus. What part gave way in Mr. Harrison's case is not mentioned.

The second explanation, namely, that there was perforation through a chronic ulcer, appears the more probable one. If this were the case, the ulcer must, of course, have been in the anterior wall of the bladder, near the apex; its formation having probably arisen from, or been favored by, the patient's constitutional (syphilitic) cachexia, co-existing with prolonged, severe straining. Adhesions having slowly formed under its influence, between the bladder at that part and the abdominal wall, just above the pubes, thus preventing any escape of fluid into the pelvis, a strong effort in micturition must have finally caused the rupture, and the extravasation of urine into the areolar tissue, with the consequences which followed. By the time the sloughs had separated, a wall of lymph having become orga-

nized opposite the perforation, further extravasation was prevented. That this view of the occurrence is the right one is strengthened by the light thrown upon it by a case of Mr. Bartleet's, in the General Hospital, Birmingham, an account of which appeared in the *Lancet* (vol. i, 1876), of which the following is a brief epitome: The patient, an engineer, aged fifty-three, "had always enjoyed excellent health, and followed his occupation uninterruptedly." On stooping, suddenly and rapidly, to pick up a bar of iron, he was seized with severe pain at the lower part of the abdomen, followed by inability to pass his urine, which had to be drawn off by a catheter, the point of which, being brought into contact with the upper part of the bladder when the handle was depressed, occasioned very acute pain. He died on the eighth day after his first attack, with obscure symptoms of deep-seated peritonitis, the symptoms generally having "appeared to point to an acute strangulation of the intestines," for which the patient was at first carefully examined, rather than to the state of things discovered after death. The autopsy revealed a large quantity of solid lymph matting the organs of the pelvis together, especially between the ileum and bladder, about an inch from its apex; and at this part of the bladder, on its posterior aspect, an ulcer was discovered, exactly resembling chronic gastric ulcer. "The ulcer obviously dated further back than the present illness, and had apparently gone through all its stages without any symptoms, and while the patient continued to follow his accustomed occupation." The act of stooping was considered to have caused a slight laceration in the adhesions between the ileum and bladder, which allowed a little urine to be discharged into the peritoneal cavity. The absence of any symptoms of diseased bladder was remarkable, both in this case and in the one I have narrated; the movement to raise the iron bar having been obviously the immediate cause of the "slight laceration" in the one case, and the effort in micturition that of the rupture in the other.

Syphilitic Diseases of the Lachrymal Apparatus.

Syphilitic lesions of the lachrymal gland, of the lachrymal caruncles, and of the lachrymal passages—all, except the latter, of uncommon occurrence—are treated of by Dr. Charles S. Bull, Surgeon to the New York Eye and Ear Infirmary, in the *New York Medical Journal and Obstetrical Review* for April, 1882. Dr. Bull gives a concise summary of the meagre literature of the subject, but his remarks are mostly from a clinical point of view. He alludes to a case of affection of the lachrymal gland in his own practice, in which the organ became inflamed in consequence of extension from an orbital periostitis. The entire contents of the orbit having been removed, to relieve the excessive pain, the gland was found generally enlarged, the hypertrophy being mainly due, however, to an increase of the connective tissue elements rather than of the proper glandular structure. Two cases of gummy infiltration of the caruncles, published by Dr. R. W. Taylor, being the first on record, are quoted

in detail, on account of their rarity. Osteo-periostitis gummosa of the lachrymo-nasal canal has not been observed by the author, but Panas, Galezowski, and Larebière are quoted as mentioning its occurrence. Under the head of treatment, the following advice in regard to inflammation of the sac is noteworthy: If the inflammatory action is severe, leading to the secretion of a glairy mucus or muco-pus, with a swelling over the seat of the sac, and there is good reason for suspecting a stricture of the duct, from whatever local cause, in the nose, do not resort to operative interference until internal medication has been tried faithfully. Ophthalmic surgeons are too prone to slit up the canaliculi and incise a stricture of the nasal duct, in cases of syphilitic origin, deeming medical treatment useless in such cases, before even giving it a trial. The use of mercury here must be prompt, and its effect must be rapidly produced, or the disease may extend from the lining of the canal to the bony walls. An excellent method of administering mercury in these cases is to use two drachms of mercurial ointment, by inunction, upon the inner aspect of the arm or side of the chest, and at the same time give the mild chloride internally, in small doses every hour or two, carefully watching for the first symptoms of the action of the drug. In many cases a beneficial effect will be observed on the third or fourth day, and then the mercury may be either entirely discontinued, or given in smaller doses at longer intervals. In many cases complete recovery follows such a course of treatment; all signs of inflammation and obstruction in the duct disappear, and its patency is restored without any incision or probing.

Removal of Benign Tumors of Breast Without Mutilation.

Professor T. Gaillard Thomas, Surgeon to the New York State Woman's Hospital, contributes to the April number of the "*New York Medical Journal and Obstetrical Review*," a paper in which he expresses himself in favor of removing benign tumors of the breast as a rule, because the mere presence of a tumor in the breast usually renders the patient apprehensive, nervous, and often gloomy, while, with our present improved methods of operating, the patient is exposed to slight risks, the danger of growth of the tumor is removed, and with this disappears at the same time that of the subsequent degeneration of a benign into a malignant growth. If in addition to these advantages, we can add the avoidance of all mutilation to the person, we have strong grounds for departing from the practice of non-interference. The method of operation described Dr. Thomas has practiced thus far in a dozen cases. He distinctly states that it is entirely inappropriate for tumors of malignant character, and that it is applicable neither to very large nor to very small benign growths, being insufficient for the former and unnecessarily radical in its character for the latter. The growths for the removal of which he has resorted to it have been fibromata, lipomata, cysts, and adenomata, and have varied in size from that of a hen's egg to that of a duck's egg or a little

larger. The operation is thus performed: The patient standing erect and the mamma being completely exposed, a semicircular line is drawn, with pen and ink, exactly in the fold which is created by the fall of the organ upon the thorax. This line encircles the lower half of the breast at its junction with the trunk. As soon as it has dried the patient is anesthetized, and with the bistoury the skin and areolar tissue are cut through, the knife exactly following the ink line until the thoracic muscles are reached. From these the mamma is now dissected away until the line of dissection represents the chord of an arc extending from extremity to extremity of the semicircular incision. The lower half of the mamma which is now dissected off is, after ligation of all bleeding vessels, turned upward by an assistant and laid upon the chest walls just below the clavicle. An incision is then made upon the tumor from underneath, by the bistoury, a pair of short volsella forceps is firmly fixed into it, and, while traction is made with it, its connections are snipped with scissors, the body of the tumor being closely adhered to in this process, and the growth is removed. All hemorrhage is then checked, and the breast is put back into its original position. Its outer or cutaneous surface is entirely uninjured, and the only alteration consists in a cavity at the former situation of the tumor. A glass tube with small holes at its upper extremity and along its sides, about three inches in length and of about the size of a No. 10 urethral sound, is then passed into this cavity, between the lips of the incision, and its lower extremity is fixed to the thoracic walls by India-rubber adhesive plaster, and the line of incision is closed with interrupted suture. In doing this, to avoid cicatrices as much as possible, very small round sewing-needles are employed; these are inserted as near as possible to the edges of the incision, and carry the finest Chinese silk. After enough of them have been employed to bring the lips of the wound into accurate contact, the line of incision is covered with gutta-percha and collodion, and the ordinary antiseptic dressing is applied. If the glass drainage tube acts perfectly, there is no offensive odor to the discharge, and the temperature does not rise above 100°; the tube is in no way interfered with until the ninth day, when the stitches are removed. If, on the other hand, the tube does not appear to perform its function satisfactorily, it is manipulated so as to cause it to drain all parts of the cavity, and warm carbolyzed water is freely injected through it every eight hours. On the ninth day, when the stitches are removed, the tube is removed likewise.

External Biliary Fistula.

Dr. J. M. Booth thus writes to the *Lancet*:—

The following case, which recently came under my observation, is, by reason of its somewhat rare occurrence, worthy of being recorded:—

The patient, a lady aged seventy-seven, had for ten years suffered from well marked attacks of hepatic colic; and, until three years ago, these occurred at intervals of a few weeks. Toward the end of September, 1878, I attended her.

during an unusually severe attack, which lasted for several days. The attack was accompanied by retching and jaundice, but, though the stools were repeatedly searched, no gall-stones were found. Since then she has been entirely free from these seizures, only complaining from time to time of slight pain or uneasiness in the right hypochondrium. In June, 1881, a painful swelling appeared on the right side, which remained some time before it became red and burst, giving exit to a scanty yellowish discharge. Save its persistence, she noticed nothing unusual, until, one night toward the end of December, while preparing to retire, she discovered a hard, black point protruding from the orifice of the wound. As it hurt her on being touched, she had recourse to a hair-pin, with which, after one or two vain attempts, she succeeded in dislodging a hard, black body, about the size of a large pea. Next day two concretions of a similar size were passed.

On calling, I found the objects to be medium-sized gall-stones, about a quarter of an inch in diameter. On examination of the abdomen a depression of the integument was noted round a small wound about a quarter of an inch in breadth, situated on the right side, nearly midway between the umbilicus and the crest of the ilium. A thick, indurated band, of about an inch in breadth, could be felt deeply through the abdominal wall, passing up toward the gall-bladder until it was lost over the site of that organ at the margin of the costal cartilage. A scanty sero-purulent discharge, slightly tinged with bile, continued to ooze from the opening. Several more gall-stones have since been extruded, varying in size from that of a millet-seed to that of a pea. Further than this there is nothing worthy of remark, save that the formation of the fistula and the appearance of the calculi explain the abrupt leave-taking (now three years since) of the patient's periodic and painful visitant.

REVIEWS AND BOOK NOTICES.

BOOK NOTICES.

A Treatise on the Science and Practice of Medicine; or the Pathology and Therapeutics of Internal Diseases. By Alonzo B. Palmer, M.D., LL.D., Professor of Pathology and Practice of Medicine in the University of Michigan, etc., etc. pp. 903. New York: G. P. Putnam's Sons, 1882. Price in cloth \$5.00; in leather \$6.00.

This volume has been prepared with the view of filling a void in medical literature which the author believes to exist, namely, a work on Practice of Medicine and Therapeutics viewed from an American standpoint. It has been stated that climatic causes so influence disease and remedies, that they will assume different phases and present varying degrees of potency in different countries. Believing this to be so, Dr. Palmer has described them as he finds them after a long experience in our own country;

which feature alone will make his book a valuable addition to every physician's library.

Lectures on Venereal Diseases. By W. F. Glenn, M.D., Professor of Anatomy and Venereal Diseases in the Medical Department of the University of Tennessee, etc., etc. pp. 259. Nashville, Tenn.: Wheeler & Osborn, Printers, 20 N. Cherry St. 1881.

This a very good book and well worth reading. It consists of a series of lectures delivered on venereal diseases by the author. He assures his hearers of the truth of the comforting doctrine of the curability of syphilis, and makes some very sensible and practical remarks on the period that should elapse between the contraction of the disease and marriage. Syphili-phobia (the dread of syphilis) is a far worse disease to contend with than syphilis, for we can cure the latter, but the former is hard to remove from the mind. We would wish for more space to more fully notice this really good book. The presswork, also, is excellent, type large and clear, though the paper is not so good, but this makes no difference when the material printed on it is so excellent.

Chronic Bronchitis; its Forms and Treatment. By J. Milner Fothergill, M.D. With numerous illustrations. pp. 158. Price \$1.50. New York: G. P. Putnam's Sons. 1882.

This book, while intended for practitioners, is designed especially for those about commencing practice. A great consideration in all books is that they may be prepared so as to make pleasant as well as instructive reading. Dr. Fothergill possesses this happy faculty in a marked degree. When he writes he always tells something new, and he does so in easy and attractive language. It must be remembered by authors that all men do not possess an equal power of comprehension. That which may be easily grasped by some minds will prove but unintelligible jargon to others. This author so writes that what he means to convey can be easily comprehended by all, thus making his book a very valuable one.

Physical Education; or, the Health Laws of Nature. By Felix L. Oswald, M.D. pp. 257. New York: D. Appleton & Co. 1882.

Dr. Oswald has written some excellent articles on this subject, and his book is a very good one. He discusses in a sensible and intelligible manner the various laws for the preservation of health, and clearly points out the penalty of their disregard. His language and style are excellent. We are constrained, however, to criticise the tendency he exhibits, more especially in the introductory chapter, to bring religion into a work on hygiene. There is a place for everything, and this is hardly the proper place to discuss religion.

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IMPRESSIONS.

The force or power of impressions is as yet an imperfectly understood factor in physiology or pathology. The old story is familiar to all, of the convicted criminal, who was placed in a bathtub, and being blindfolded was told that he was to be bled to death. A shower bath was so arranged that the water fell on and trickled from his wrist in the water below. Imagining that he was in reality bleeding to death, though in truth no wound had been made on his body, this unfortunate succumbed, and finally died, merely through an impression, or the force of imagination. It was recently reported that a man who had been vaccinated was subsequently informed that the person from whom the vaccine virus was derived was crazy; he brooded over this fact and finally became crazy himself.

The most remarkable case, however, recently occurred in our city. A woman aged fifty-eight, in apparently good health, suddenly died; her sister, aged fifty-six, was so impressed that she died in a few minutes, and to cap the climax, a

third sister, aged fifty-two, who was called on the death of the other two, suddenly died, all within half an hour. Of course, it is most likely that all of these women, who were very fleshy, had some heart trouble, but still, allowing this, it would seem that *impression* must have had much to do with the sudden deaths. It is, to say the least, an interesting field of observation, and one in which much is yet to be learned, and we desire to direct thought in this direction. We would be glad to have our readers furnish us their experience on this subject.

AMERICAN MEDICAL ASSOCIATION.

In a short time this representative body of American Physicians will convene in annual session. It may do no good, but still we will take this occasion to give a little advice. It has been reported that Professor GROSS said of the last annual meeting, in Richmond, that while socially it was a success, professionally it was a failure. We have considered that the form and method of the meetings of the State and American Medical Societies was fundamentally wrong. The system of reading papers we can conceive to be of no good, further than to advertise the readers thereof, while they consume much valuable time. It would seem to us much better for our representative men to annually assemble and openly perform two functions, for which they are supposed to meet:—

1st. Social enjoyment.

2d. To enact rules for the government of the profession.

The papers, to which but few listen, could be given much more publicity in the columns of journals, while, by dispensing with the time consumed in their reading, much more time would be allowed for the transaction of business that would prove of real benefit to the profession, while more time would also be allowed for amusement and recreation, which our hard-worked brethren so much need. This hint may, we trust, be of value to those of our readers who may be delegates to the next meeting of the American Medical Association.

"DIAMOND CUT DIAMOND."

The recent action of the New York State Medical Society concerning homœopaths has been commented upon from various sources, we are glad to say; but the most severe thrust has been inflicted by the homœopaths themselves. At a recent meeting of the Homœopathic Medical Society of Lancaster county, the following resolution was unanimously adopted:—

"Resolved, That it is the sense of this meeting, that since the practice of homœopathy has established for itself an honorable position in the estimation of the community, against all the opposing forces that the Old School could bring to bear against it, there is no advantage or prestige to be derived by homœopathic physicians in consulting with *allopaths*, and, therefore, the recent action of the *Allopathic* Medical Society of the State of New York, in resolving in future to consult with them, was entirely gratuitous."

The leaders of this movement in New York have ample reason to feel uncomfortable. In their own school they are almost universally condemned; by homœopaths they are ridiculed; but few, outside of their own clique, approve of their action; the best members of the profession uniting in the openly expressed hope that the innovating society shall be debarred from participation in the deliberations of the American Medical Association. The point, however, upon which we wish particularly to dwell, is the fact, the degrading fact, to those who engineered the move, that, far from feeling flattered, the homœopaths really ridicule, and laugh in their sleeve at, the action of the notorious few who have sacrificed their consciences to—well, to what?

NOTES AND COMMENTS.

Ammonia Poisoning.

Dr. A. A. Browne reports the following case in the *Canada Medical and Surgical Journal*:—R. W., aged 54, had been drinking heavily for two weeks, and on Sunday evening, Feb 5th, 1882, he took, by mistake, a draught of strong liquor ammoniæ. In a few minutes, when he had discovered his mistake, he fell insensible on the floor. His brother made him swallow some milk, with considerable difficulty. Previous to the accident, he had taken two plates of strong soup. Free emesis was procured, after which he appeared rather better. The vomited matter

smelt strongly of ammonia, and contained some blood. Voice husky, but no dyspnoea. At 10 P.M. he was very weak; pulse 130 and weak. He vomited every fifteen or twenty minutes, and the vomited matter was almost pure blood, partly in clots and partly fluid. Pain in the epigastrium was relieved for a few minutes after vomiting, but soon returned. Features pinched, surface generally cool and covered by a clammy sweat. Urine not suppressed. He constantly hawked and endeavored to clear his throat, but the voice, though husky, was not lost. Respiration not impeded. He remained in this condition until about 7 A.M., when the hemorrhage ceased and the vomiting became less frequent. During the day he remained in much the same condition, constantly hawking and unable to retain fluids, the smallest mouthful of water bringing on vomiting almost immediately. He complained of pain on the right side of the chest. Pulse very weak and rapid. Toward evening he became delirious and remained so all night. The next day his condition remained much the same; some delirium, but less noisy. Had morphia, gr. ss, and liquor atropiæ, ℥j, hypodermically, which gave him a comparatively good night's rest. Next morning (February 8th) he seemed easier and much more comfortable. Pulse still very weak; quite rational; cannot retain anything on his stomach; hawks and spits a great deal, and occasionally, but rarely, vomits. In the evening he was much weaker, but sensible, and spoke intelligently of his case, expressing the conviction that he would not recover, and that the mucous membrane of his œsophagus and stomach were sloughing. His opinion seemed to be justified by the odor of what he hawked up, which was exceedingly offensive. Abdomen very much swollen and tympanitic, but little, if any, tenderness. Bowels move involuntarily. His condition remained much the same until he died, of exhaustion, at 4.30 P.M. on Thursday, February 9th, about 94 hours after taking his fatal dose. He was quite sensible until about a quarter of an hour before death.

Urine of Acute Pneumonia.

At a recent meeting of the Medical Society of the College of Physicians (Dublin *Journal Medical Science*), Dr. Walter Smith made a communication relative to a peculiarity observed in the urine of a patient suffering from acute pneumonia. A young gentleman, aged 22, not previously very robust, caught cold. He was seized with rigors, headache, and vomiting, and the temperature ran up to 105°. He complained of intense pain over

præcordial region. On the fifth day the physical signs were detected, of early consolidation, in the base of the left lung. The other lung became involved, and the young man died without ever rallying. Some of the urine passed on the fifth and sixth days was examined. That of the fifth was very turbid with lithates; that of the sixth was nearly clear. Each specimen examined was bright colored and acid; chlorides markedly deficient.

1. *Serum albumen*.—Tested by the usual methods, a very moderate amount could be precipitated; no distinct flocculi.

2. *Serum globulin*.—Saturation of the urine with sulphate of magnesium threw down an abundant precipitate of globulin.

3. The urine, freed from albumen, yielded an opaque white precipitate with tannic acid, and also with phospho-tungstic acid, and it was rendered turbid by alcohol. The tannic precipitate dissolved by heat, and was re-precipitated on cooling. These reactions suggested the presence of peptone; but, since the urine, when freed from mucus (by acetate of lead), and albumen (by precipitation along with basis acetate of iron), yielded no color with Millon's test, and failed to give the xantho-proteic reaction, the presence of any albuminoid seems to be negatived. Moreover, all attempts to get the characteristic biuret reaction for peptone ended in failure. The patient had been treated with sulphate of quinia, but direct testing of the urine for that alkaloid gave a negative result. This case elicited some discussion, but without any conclusion as to the nature of the precipitate.

The Chairman (J. W. Moore, M.D.) remarked that the outcome of the case, from a clinical standpoint, was that it afforded another proof that pneumonia is an essential, continued fever, manifesting itself, in connection with the lungs, only after a lapse of a certain period of invasion. In fact, the lesion of the lungs was analogous to the condition of the intestines in typhoid fever, or to the condition of the skin in the exanthemata or eruptive fevers.

Iodoform for Soft Sores.

In the *British Medical Journal*, Dr. Walter Whitehead says that iodoform appears to be one of the most efficacious drugs in the treatment of the syphilitic non-infecting soft sore, when not unduly inflamed. It has, however, the unfortunate counterbalancing disadvantage of attaching to the patient the liability of unenviable suspicion, the public having become keenly alive to its distinctive and penetrating odor, and

having also acquired an appreciative knowledge of the principal purpose for which the drug is most frequently used. He has succeeded, he thinks, in obviating this objectionable feature, without, apparently, sacrificing any of the therapeutic advantages of the drug, by using it in the following manner: He first very carefully cleanses and dries the sores, by means of little pledgets of bibulous paper, and then, by means of a camel's hair pencil, applies freely over the surface of the sores a solution of iodoform in ether. The ether rapidly evaporates, and leaves the iodoform uniformly spread in an impalpable powder over the sores. To insure a free application, the latter part of the process may be repeated and allowed to dry. When perfectly dry, each sore is given a coating of collodion, which is allowed to overlap, about a quarter of an inch, the area of each sore. Before the collodion has had time to dry, a pinch of absorbent cotton wool is placed on each patch, as a protection against the rough contact of clothing. This dressing is allowed to remain undisturbed for twenty-four hours, when the firm film which forms may be gently removed and a fresh coating applied. This treatment is continued day by day until all the sores have quite healed. He has found that a piece of gold beater's skin may be substituted for the collodion after the application of the iodoform. This process will suppress the odor, while a further advantage will be gained in the protection afforded by the collodion against auto-inoculation, and also against the risk of contagion from others coming in contact with the sores.

Anatomy, Physiology, and Pathology of the Blood Corpuscles.

Dr. Alexander Duane, of New York, concludes his article upon this subject, in the April number of the *New York Medical Journal and Obstetrical Review*. The article as a whole embraces a historical and critical review of the part played by the corpuscular elements of the blood under normal and pathological conditions. For the red corpuscles the author proposes the term "erythrocytes." He thinks that Hewson's idea, that these corpuscles are spherical sacs, containing a central globule of uncolored substance, although certainly false in the majority of cases, is not indefensible, the appearance of a central spot being due, perhaps, in some cases, as Arndt conjectures, to a residual granule, a relic of those that, according to the latter's hypothesis, once constituted the whole corpuscle. The criticism

is suggested that the means employed by Hayem to demonstrate his "hæmatoblasts" are just the ones that produce disintegration and decolorization of the red corpuscles, resulting in appearances closely resembling what Hayem describes. Norris' colorless, biconcave, discoid forms seem open, Dr. Duane thinks, to a similar objection. Malassez's modification of Gower's hæmatocytometer, does away with one source of inaccuracy in the use of the instrument, since the depth of cell can always be adjusted to exactly 0.2 mm. The author differs with Obrastzow, Arndt, Norris, Flint, and others, in the conviction that nucleation of the white corpuscles is a normal condition, and not attributable to post-mortem coagulation of granular "nuclear matter"—the chief reason for his dissent being that nucleated corpuscles are observed in the vessels of living animals. The erythrocyte of the adult cannot be said to be capable, as a rule, of amoeboid movement or of division, although such may be the case under morbid conditions. The remainder of the paper, which does not readily admit of a synopsis, includes a discussion of the formation and destruction of the corpuscular elements, the part taken by them in physiology, and a consideration of certain pathological conditions, notably anæmia, chlorosis, and leucocythæmia.

Treatment of Diphtheria.

In the *British Medical Journal*, Dr. H. Cripps Lawrence thus writes: The following combination of the glycerols of tannin and carbolic acid has proved itself, during a considerable experience of diphtheria and scarlet fever, a highly efficient application in my hands, viz:—

R. Glycerini acidi tannici, 3 vij
Glycerini acidi carbol., 3j. M.

In the application of glycerine as an absorbent, it is of practical importance that a small proportion of water should be added to it. In order to secure this, a sufficiency of glycerine should be placed in a saucer, and a throat brush dipped in water should first be stirred into the glycerine before applying it to the throat and fauces. The combination above mentioned has been found practically the most efficient proportion for securing the necessary astringent and antiseptic results, without irritation. An application, twice or at most thrice, in the twenty-four hours, secures the utmost benefit the remedy affords. It is seldom that any additional local remedies are required, but it is wise to precede the application of the glycerols with gargling the fauces and washing out the mouth with a solution of per-

manganate of potash and water, and to use the sulphurous acid spray, the double advantage that follows being that the fauces are the better prepared to benefit from the glycerine, and that the safety of the practitioner is increased in the event of the patient expectorating any false membrane during the act of swabbing. To further increase the safety of the medical attendant, a glass screen placed between him and the patient will afford protection, without limiting the efficiency of the procedure.

Congenital Fistulæ in the Sacral Region.

At a recent séance of the Soc. de Chirurgie, M. Terillon said that he had observed three cases where such fistulæ existed. The first, a man 35 years of age, had from birth a fistula over the sacrum, just between the upper and inner borders of the gluteal masses. This fistula extended to a depth of three centimeters, and gave issue to a liquid containing fat and epithelial detritus. Around this fistula were several others which had supervened on abscesses; there appeared to be no bone lesions. After ablation with the scalpel histological examination demonstrated that the fistulous passage was formed of epidermic tissue.

In the two other cases reported by M. Terillon, the situation and character of the fistula were identical with the one just considered.

These subcutaneous congenital fistulæ are evidently malformations. But what is their significance? Are they cases of spina-bifida in its most simple form? Or is there a retardation in the junction of the two borders of the vertebral to which the term "posterior umbilici" has been applied? M. Terillon inclines toward the latter hypothesis, as there is absence of bone lesions, and also on account of the little depression sometimes observed in infants at this point.

M. Desprès has observed one such case, and adopts fully the same theory regarding their production.

M. Gueniot has remarked the depression at the point spoken of by M. Terillon, in several children.

Primary Epithelioma of the Tonsil.

Dr. D. Bryson Delavan, of New York, relates a case of primary epithelioma of the tonsil, in the *New York Medical Journal and Obstetrical Review*. Cancer of the pharynx, he remarks, although a somewhat rare affection, is one fraught with such serious results that no opportunity for investigating its nature or devising

means for its relief should be lost. That the tonsil should be a favorite point of departure for malignant disease seems not unnatural, when the anatomical position and structure of that organ are considered. The very qualities, however, which render it liable to attack, afford, on the other hand, the greatest possible measure of hope for a favorable prognosis. For, if a diagnosis could be made before the disease had involved the surrounding tissues, the gland might, in most cases, be extirpated with comparative ease, and by the natural passages, thus avoiding the formidable operation by external incision and the almost certain recurrence of the trouble. The paper concludes with a bibliography of the subject.

Treatment of Scrofulous Ulcers of the Cornea.

This is a form of keratitis which often comes under the care of the general practitioner, and as injudicious treatment may lead to the formation of opaque cicatrices, the following recommendations regarding treatment, made by M. Dehenne in *Le Progrès Médical*, may prove of service:—

1st. Instill daily into the eye four or five drops of the following collyrium:—

R. Atropiæ sulphat (neutral), gr. j
Aque destillat., f3 iiss. M.

2d. Abstain from every form of metallic collyrium, which often leave indelible marks, veritable metallic leucomata. Do not use any collyrium containing eserine, for affections of the cornea are frequently accompanied by iritis, and there would be danger of formation of posterior synechia.

3d. Each evening insert between the eyelids, with a small camel's hair pencil, a portion, about as large as a pea, of the following unguent:—

R. Hydrarg. oxid. flav., gr. xv
Ug. petrolei, 3 ss. M.

4th. Apply four times daily over the eye compresses soaked in warm chamomile tea.

5th. Administer a tablespoonful of cod-liver oil every morning.

Laryngeal Electrization.

The *Lancet* says that Rossbach has endeavored to discover whether the nerves and muscles of the human larynx can be excited directly by electrical stimulation applied through the skin, and his experiments enable him, he believes, to give an affirmative assurance. An individual was selected, tolerant of laryngoscopic examination, and a knob-shaped, moist electrode was placed midway between the larynx and the sternum, in

front of the anterior edge of the sterno-mastoid, being pressed as deeply in as could be without causing much pain. The other electrode was placed in some indifferent situation on the back of the hand. With this arrangement, whenever an opening or closing shock was sent between the poles, on the side on which the electrode was placed in the neck, a distinct contraction could be observed. The vocal cord moved inward in its whole extent, together with the arytenoid cartilage. The closure contraction was the strongest when the cathode, the opening contraction when the anode, was placed on the neck. Immediately after the stimulation a movement of swallowing occurred, which rendered further observation impossible. If the stimulation was made while a note was being uttered, the effect was to increase the pitch without interrupting the sound. The effect is ascribed to stimulation of the recurrent laryngeal nerve.

Experiments with faradization yielded the following conclusions: The passage of a strong current transversely through the larynx, an electrode being placed on each side of the thyroid cartilage, had no effect on the vocal cords or on the arytenoid cartilages. The free upper edge of the epiglottis was drawn forward and its lower part backward. The aryteno-epiglottidean folds were moved inward, together with the false vocal cords. If one electrode was placed on the side of the larynx and the other on an independent place, the effect was the same, but was confined to one side. A slight movement of the vocal cord was produced by an attempt to faradize the recurrent laryngeal nerve of one side, and the effect was still more marked if an electrode was placed over each recurrent laryngeal, a distinct tremor of the arytenoid cartilages being produced. Hence, Rossbach concludes that, in addition to the reflex effect of a painful cutaneous stimulation and to the effect on the larynx of stimulation of the external muscles, electricity applied outside the larynx can directly stimulate, feebly but unquestionably, the laryngeal nerves.

SPECIAL REPORTS.

NO. V.—OPHTHALMOLOGY (Continued).

BY CHAS. S. TURNBULL, M.D.

Congenital Dislocation of the Crystalline Lens; Diploopia.

As ophthalmological anomalies, P. D. Keyser (*Archiv. Ophthal.* Vol. x, No. III) reports three cases of congenital dislocation of the crystalline lenses, in one (MEDICAL AND SURGICAL

REPORTER, July 10th, 1880) aged 26, the lenses were dislocated differently but not symmetrically, as is usually the case. In the R. E. the lens was dislocated inward, and the L. E. directly upward. In the other two cases, which were also anomalies, the lenses were dislocated directly downward, entirely out of the region of the pupil. These two cases were daughter and mother. A case of *double pupil*, *diplochoria*, in but one eye of a lady aged 26. There was a broad band, $1\frac{1}{2}$ mm. in width, running across, from margin to margin of the iris, at an angle of 110° . It extended only from the extreme pupillary edges of the iris, and was of the same thickness and color and continuous structure of the iris.



Patient had never suffered from any inflammation of the eye. As a congenital anomaly of the iris, it was rare, as occurring in but one eye. By a small incision through the cornea, in the lower and inner quadrant, K. introduced a delicate pair of iris forceps, grasped the band in its entire breadth and cut it off. Then its lower attachment was divided and the protruding iris was replaced from the corneal incision. Pilocarpine solution was instilled into the eye. No inflammation followed, the pupil became round, and the action of the iris has been good ever since.

J. J. Chisholm (loc. cit.) reports two cases of *sympathetic ophthalmia*, as a sequel to cataract extraction, and of iridectomy in glaucoma. Pain and inflammatory process promptly checked by neurotomy of the lost eye. Dr. C. makes the point, *i. e.*, in an eye in which nerve cutting was effected, there was a complete effacing of a corneal staphyloma.

Wm. C. Ayres (loc. cit., p. 278) in examining a glioma retinae endophytum, mentions his discovery of a peculiarly interesting condition, viz: a *gliomatous infiltration of the lens*. The glioma cells had passed both without and within the canal of Petit, along the whole length of the suspensory ligament, up to the lens capsule. When outside of the ligament they seemed to have impinged upon the capsule and passed around it. When within they seemed to have passed directly to the lens and to have forced themselves up beneath the fibres of the ligament, as they attached themselves to the anterior capsule. Though they had not disturbed the continuity of the capsule at any other place, just under the attachment they had broken through and entered the body of the lens. *They had also entered into the body of the capsule itself, and split it into distinct layers, to a distance of some mm. from the capsular rent.*

In another case Ayres, in examining a phthisical eye (phthisical after a severe inflammation in childhood), found *bone within the lens capsule, i. e.*, "the lens was full size, normal in curvature of capsule, while at the same time the body of the lens was entirely replaced by bone. The space within the capsule was filled with true bony tissue, having a perfect system of canals and typical bone corpuscles, with the exception of a narrow zone of connective tissue, holding the same relative position as the glioma cells in the case of gliomatous infiltration. Ossification had taken place in layers parallel to the connective tissue next to the capsule, and where these layers of bone were thin, it appeared as if the original fibres had ossified, but, of course, this is impossible, since the lens, being epithelial tissue, cannot ossify."

Dr. Chas. J. Kipp, of Newark, N. J., reports, in brief (*Archiv. f. Ophthal.*, Vol. x, No. 3), the *Transactions of the American Ophthalmological Society for 1881*.

Wm. F. Norris, of Philadelphia, read a paper *On the Administration of Anesthetics in Bright's Disease of the Kidneys, and on some Cases of Sudden Death after Cataract Operations.*

Two deaths. In both cases the patients were etherized; both died comatose, and, in both, careful autopsies revealed no organic lesions, except those belonging to Bright's disease. The first patient was a child five months old, and in good health, upon whom he operated by discission. The child recovered consciousness, but died soon afterward. Intense congestion of kidneys, cloudy swelling, and fatty degeneration of epithelium, most marked in the cortical portion. There was no history of hereditary disease. The second patient was a woman, sixty years old, supposed to be in perfect health. Recovery from anaesthesia was prompt. On the evening of the following day she was somewhat feverish, and the urine diminished in quantity and loaded with urates. From fourth to ninth day she sat up and felt pretty well. After that time unfavorable symptoms manifested themselves. On the sixteenth day she was delirious. On the seventeenth day urine was found to contain a small quantity of albumen, and hyaline, and fatty and granular casts. Patient died on eighteenth day after operation. Autopsy showed all organs to be healthy, except heart, in which there was moderate enlargement of left ventricle; and the kidneys, which were markedly congested, and showed increase of interstitial tissue, fatty degeneration of epithelium, and cast material in the uriniferous tubules.

In the discussion which followed the reading of Dr. N.'s paper, Dr. Mathewson, of Brooklyn, said he "had extracted cataracts, under ether, from patients known to have Bright's disease and who recovered promptly." Dr. Carmalt, of New Haven, related two cases in which death followed cataract extraction performed without anesthetics. In one case death took place four hours after operation, and seemed to be due to shock, which might possibly have been avoided by the use of an anæsthetic; no autopsy. In the other case the patient had had diabetes, from which she had apparently recovered. Dr. C. assisted in the operation. There was no attempt at repair. Patient failed rapidly and died on fourth day. Dr. Norris remarked that the action of ether, in many cases of fatty heart, was beneficial rather than otherwise. Dr. Noyes, of New York, had used ether and chloroform freely in a large number of cases, but had not had a fatal result in consequence. He had used ether when he knew there was Bright's disease, and also in cardiac complications. He is in the habit of using bromide of potassium, and sometimes hydrate of chloral, before the operation, and thinks that in a certain proportion of cases the occasion for the use of anesthetics has thereby been considerably diminished. It has been his practice, where anesthetics are given, to produce simply the primary anæsthesia, make the corneal incision, and then allow the patient to fully recover consciousness, which is utilized in the subsequent steps of the operation."

(Concerning the administration of anesthetics, especially ether, to patients suffering with any form of chronic kidney disease, there seems to be but one opinion, as expressed by all authorities, *i. e.*, that such procedure is, as a rule, followed by fatal results, and the weight of testimony confirms this assertion. Nay, it goes farther. It condemns such administration as reprehensible, and if operators insist upon setting aside experience, and by so doing trifle with human life, it will not be long before a well grounded suit for damages will bring some careless, or call it obstinate, administrator up with a round turn. We would deprecate Dr. Mathewson's views, if reported correctly, and so also those of Dr. Noyes, if the latter did not beg the question after saying "he had used ether and chloroform freely in a large number of cases;" "where he knew there was Bright's disease and cardiac complications," by adding, "It has been my practice, where anesthetics are given, to produce the primary anæsthesia, make the corneal incision, and then allow the patient to fully recover consciousness."

This we cannot admit as "using anesthetics freely," or even operating under anæsthesia. In conclusion, we would warn the inexperienced, and would suggest that it will not be many years before juries will refuse to render such verdicts as exonerate the criminally careless administrators of fatal doses of anesthetics, but they will call for post-mortem examinations of the kidneys, heart, etc., and in proportion as these are found, or known to have been, diseased will they (administrators, operators, etc.) be held responsible. T.)

Of especial interest in this connection is a paper read by Hasket Derby, M.D., of New York, *On Anæsthesia and Non-anæsthesia in the Extraction of Senile Cataract, with Comparative Statistics of 200 Cases.*

The author avoided anesthetics as much as possible. Of 200 uncomplicated cases of senile cataract 100 were operated under ether, and 100 without anæsthesia. The average age of the patients operated under ether was 67.7, without, 65.8. Loss of vitreous in fourteen with ether, and nine without. The duration of treatment was 18.3 with ether, 16.5 without. Vision, $\frac{1}{60}$ or more, was obtained in eighty-one with ether, and eighty without. Partial success (vision from $\frac{1}{12}$ to $\frac{1}{60}$) in eight cases with ether, and nine without. There was reasonable prospect of success from a secondary operation in two of the last-named operated under ether, and one without. The total failures were nine with ether, and one without. In the discussion which followed, Dr. D. B. St. John Roosa, of New York, and Dr. H. W. Williams, of Boston, thought that the advantages obtained by the use of ether were considerable.

Dr. Kipp, of Newark, thought that the danger of escape of vitreous is much greater than without anæsthesia. Dr. B. Joy Jeffries, of Boston, saw no objection to the use of ether, but does not hesitate to operate without it.

Dr. Little read a paper entitled a *Contribution to the Study of Glaucoma*, in which he gave the details of four cases; all bi-lateral. The patients were all under 20 years of age. Three of the cases occurred in one family. In all cases the eyes were hypermetropic, and in three of the cases the patients suffered also from hemorrhoids. In one of the cases acute fulminating glaucoma was developed twelve hours after the instillation of atropia, and some days later the fellow eye became glaucomatous. The author thinks the fact that three of his cases occurred in one family is especially instructive, as showing a tendency to heredity, and he infers, from the coexistence of hemorrhoids in three of these cases, and in some others observed by him, that, since in both

diseases textures supplied with a sphincter muscle are involved, a somewhat similar morbid action may take place in both.

Dr. Geo. C. Harlan related a case of *congenital paralysis of the sixth and seventh nerves of both sides*. Patient aged 18, male; marked epiphora and slight haziness of cornea. R. S. = $\frac{20}{120}$; L. S. = $\frac{20}{100}$. The author thought that the complete paralysis of the two abducens, which are so widely separated in their course after they leave the brain, pointed to a central cause and supported the view that they arise from the same nucleus.

Dr. E. W. Bartlett, of Milwaukee, who formerly saw a great deal of *Conjunctival Inflammation after the use of Atropia*, says that since he had used Merk's preparations the difficulty had entirely disappeared.

Dr. F. Buller, of Montreal, reported a case of *Sudden and Complete Blindness after Large Doses of Quinine*,

but as the subject had just been confined, and was threatened with puerperal septicæmia, we consider the case too doubtful to mention in detail, especially as the doses of quinine (20 grains, night and morning, for two days) were comparatively small.

Marked Narrowing of the Field, with Diminished Acuteness of Vision (Glaucoma? Kipp) Following the Use of Duboisia,

presumably due to the use of the drug, was the title of a paper by Dr. J. P. Morrell, of Terre Haute.

Dr. Noyes reported a case of *Pulsating Exophthalmos*, which differed in its history and treatment from any on record. A girl, four years ago, after some severe form of fever, was suddenly taken with a pain in the left side of the head, and about the left eye; the globe began to protrude, and within one week there was marked exophthalmos without inflammatory disturbance. For four years the condition of the eye remained substantially unchanged, except that she had occasional attacks of fugitive inflammation. While passing through Dublin, on her way to America, she had a severe attack of inflammation of the eye. On her arrival in New York she came under his observation. He found swelling of the lids, considerable ecchymosis. There was marked protrusion of the globe, and at the lower and inner angle of the orbit a projection was felt, which at first seemed to be a solid growth. Pulsation, however, was felt, and an operation was proposed. Examination under ether showed the tumor to be a distended blood vessel, which

came from the orbit, forward, and returned upon a loop. A bruit was heard over the exophthalmos, but, not upon the temple. Pressure upon the carotid completely stopped the pulsation, but had no effect upon the protrusion. From this he concluded that it was a purely vascular anomaly, and not wishing to perform so grave an operation as ligation of the carotid, and not being clear with reference to the diagnosis, he decided to ligate the angular artery, and to dissect down to the enlarged vessel, and tie it off. With great difficulty he succeeded in ligating the angular artery. Then dissecting up the protruding vessel, which was as large as a good-sized lachrymal probe, he traced it down, placing one ligature after another in the vessel, and cutting between them. He demonstrated that it was a vein, which he finally ligated at the speno-maxillary fissure. He then concluded that it was the anterior orbital vein, coming out of the speno-maxillary fissure, and going back to empty into the cavernous sinus. The wound healed kindly. At the end of six weeks the exophthalmos had disappeared."

CORRESPONDENCE.

FOREIGN.

Letter from Europe.

ED. MED. AND SURG. REPORTER:—

My promise to write you for the REPORTER while in Europe has never been fulfilled, but to-day I determined to write you my first letter. I came abroad to study abdominal and pelvic surgery, but have really been hard at work on surgery of all regions. In order to get that for which I came such a course was necessary in some places. So I have, therefore, simply studied for six months, in the clinics of Europe, surgical operations and the antiseptic method of each clinic. It has been my pleasure to see a very large number of private operations, and thus I have seen the abdomen opened forty-seven times. Five times I have seen extirpation of the whole uterus. But as I have sent to America my Address in Gynecology, for the State Society, in which I have spoken especially of abdominal and pelvic surgery abroad, I will not speak of it again in this letter. In about 600 surgical operations, independent of laparotomies, which I have been present at, the method of antiseptics has varied with the operator. But I have not seen an operation done in Europe without *complete* antiseptic precautions; Listerism it all is, but varied to some degree by each operator. To shorten my letter, I will here say that Professor Langenbeck is the only operator whom I have seen open the abdomen without spray, and in this instance his patient rapidly developed a peritonitis. Professors Nussbaum, Volkmann and Esmarch use the spray in other operations, but with the latter

operation air, driven by a pump attached to the hospital engine, takes the place of steam. This is of much advantage, as steam clouds the room and condenses upon the windows, shutting off much light. Moreover, this method by air is the cheapest yet devised. Of the very many antiseptic agents yet devised carbolic acid is found in use everywhere, also salicylic acid; but Billroth, Nussbaum, Volkmann, Langenbeck, Küster and Esmarch all use iodoform, either in spray or in powder. All use the impervious cover for dressing. Iodoform intoxication occasionally occurs, and Prof. Küster lost one patient, from whom I saw him remove a multilocular ovarian cyst, from this effect of the drug. The gauzes from the various agents are variously applied, sometimes as compresses, sometimes as handkerchiefs, a handful at a time on this side, and another handful on that side, and a handful on top, and an antiseptic gauze rolled around it all. The mackintosh over all, more gauze roller over this, and it is completed. Thus it is usual to see it. But by Nussbaum and Küster this is completed by Lister's own method; protective to the wound and the Lister bandage over all, secured by an antiseptic gauze roller. At Kiel the antiseptic bandage is somewhat different from the others. Over the wound is placed, while the spray is in operation, some iodoform cotton, and over this a small bag of naphthaline turf; all is secured by a carbolized gauze roller; over this another bag of turf, much larger, and another roller; if a splint is required it is of glass and padded, and secured by antiseptic roller. If a joint has been resected, over all is applied, for one or two hours, an elastic roller. The limb remains elevated while the elastic roller remains. The turf is the innovation of Dr. Neuber, First Assistant to Prof. Esmarch; he is also the inventor of the decalcified bone drain. That the turf is antiseptic there is but little doubt. Neuber opened the abdomen of five rabbits, and into the peritoneal cavity of each he put a teaspoonful of the turf. This was four months ago. One rabbit died soon afterwards, and tubercle was found in its lungs; possibly a verification of Cohnheim's theory. The remaining four rabbits are living, and look well; they are fat and lively, each with a spoonful of the turf sealed up for months in their bellies. The antiseptic dressing of Neuber is difficult to excel. For instance, by his method, which consists of carbolized spray in the atmosphere during an operation, the addition of iodoform spray in the wound before closing it, the introduction of the decalcified drain, the punching of a few circular holes in the skin, and the turf dressing as I have described it, wounds are rarely ever dressed but once. No pus, no fever, nothing; when the dressing comes off the patient is well. Thus Prof. Esmarch and Dr. Neuber treat all amputations, including the hip joint, all resections of joints. They have shown me cases where the dressing was still intact, the operation having been done four weeks before. The temperature schedule shows remarkable freedom from fever. I saw Prof. Esmarch resect the knee joint to-day, and so dress the leg; this dressing is expected to stay there until the patient is well. The parts once brought together stay there. I have not seen a poultice in Europe, nor half a dozen roller bandages of

the old sort. The common drain is of rubber tube. On the extremities all operations are bloodless. In Prof. Esmarch's clinic, to-day, he resected the knee joint, and there was *absolutely not one drop of blood lost; not a single sponge or cotton pledget was used.* He brought the tissues together, applied Dr. Neuber's dressing and an elastic roller and splint. *Not a single artery was tied.* This patient goes to bed with the expectation of not being again hurt by a re-dressing. Prof. Esmarch has used this method in over one hundred cases. Can any one, in the present condition of antiseptic surgery, as seen in Europe, imagine anything so frightful as the common practice of a past surgical era, of draining wounds with strips of bandage, daily washing of them, and all the old practices. They are about gone in Europe, and will go in America, when surgeons are surgeons, and not jacks of all branches of the trade and masters of none.

R. STANSBURY SUTTON, M.D.

Kiel.

Vaccine Tuberculosis and Vaccine Syphilis.

ED. MED. AND SURG. REPORTER:—

The REPORTER of March 25th contains the comments on this subject, of Dr. I. Cappie Shand, copied from the *Medical Press and Circular*, from which I make this short extract: "I am of opinion, with reference to vaccination, that it should be optional, although apparently desirable, and that it should be put upon such a footing as to prevent it from propagating such diseases as tuberculosis and syphilis." This is Dr. Shand's opinion. Mine is, that no physician should venture to disseminate such dangerous doctrines without some foundation stronger than the very meagre and insufficient evidence he has offered. The most experienced vaccinators, and those who have had most to do with the treatment of infantile ailments, agree in the belief that disease is not communicable by vaccination. Mr. Marston, an English physician, in the performance of more than fifty thousand vaccinations, "has never seen other diseases communicated with the vaccine disease. Mr. Lees, with equally extensive experience, gives similar testimony. Dr. W. Jenner, who in six years had some thirteen thousand sick adults and children under observation, states "That in no case had he reason to believe, or even to suspect, that any constitutional taint had been conveyed by one person to another, by vaccination." Dr. West "treated twenty-six thousand infants and children" with a like experience. In opposition to all this overwhelming evidence, Dr. Shand describes one or two rather suspicious cases, which prove nothing. For a single case in point, I will relate the history of a case of tubercular disease alleged to have been transmitted by vaccination. A neighboring physician, some years ago, vaccinated a child, who not very long ago thereafter developed scrofula and died. The mother was loud in her denunciation of the doctor for causing her child's death by the use of infected virus. Subsequently she had a second child, whose health she was determined should not be endangered by this same cause, and vaccination was dispensed with. Un-

fortunately for her hopes, however, this child also developed scrofula.

In regard to syphilis being carried in vaccine lymph, I am a non-believer; but, admitting its possibility, there is, practically, very little danger. There are comparatively few cases of infantile syphilis, and no competent physician would think of using virus derived from such a source; if not from conscientious motives, then, in view of the prospect of a prosecution for malpractice. These imputed dangers are mere bugbears; but the matter in dispute might be easily tested without exciting the fears of the public, by confining the experiments to operations on condemned criminals—Guiteau, for instance. In like manner vaccination might be available as a test for insanity, for the learned experts who were examined in the case of that self-inspired assassin, decided that insanity is not only a bodily disease, but that it is also frequently hereditary.

Even if syphilis should prove to be transmissible in the way supposed, it affords no serious objection to compulsory vaccination, for syphilis in its early stage is readily cured, and, therefore, infinitely less to be feared than confluent smallpox. It is a curious fact that all the actual cases of infantile syphilis that come under notice can be traced to sources other than vaccination, and yet so few fears are expressed on the subject.

JOHN T. HUDDLESON, M.D.

Glen Mills, March 30th, 1882.

NEWS AND MISCELLANY.

Official List of Changes of Stations and Duties of Medical Officers of the United States Marine Hospital Service, January 1st, 1882, to March 31st, 1882.

Bailhache, P. H., Surgeon. To proceed to Richmond, Va., as Inspector. January 31st, 1882.

Vansant, John, Surgeon. Detailed as President Board of Survey—physical examination of officers of the Revenue Marine Service. March 18th, 1882.

Wyman, Walter, Surgeon. When relieved by Surgeon Austin, to proceed to Baltimore, Md., and assume charge of the Service at that port. March 4th, 1882.

Fessenden, C. S. D., Surgeon. To proceed to Greenport and Sag Harbor, New York, as Inspector. January 26th, 1882. Detailed as President Board of Survey for the physical examination of pilots. To meet at Boston, Mass., February 16th, 1882. February 7th, 1882.

Purviance, George, Surgeon. To proceed to Gloucester, Mass., to extend relief to shipwrecked seamen. January 12th, 1882. Detailed as Recorder Board of Survey for the physical examination of pilots. To meet at Boston, Mass., February 16th, 1882. February 7th, 1882.

Austin, H. W., Surgeon. To proceed to Cincinnati, Ohio, and assume charge of the Service at that port, relieving Surgeon Wyman. March 4th, 1882.

Godfrey, John, Passed Assistant Surgeon. When relieved by Passed Assistant Surgeon Goldsborough, to proceed to New Orleans, La.,

and assume charge of the Service at that port. March 4th, 1882.

Goldsborough, C. B., Passed Assistant Surgeon. When relieved by Surgeon Wyman, to proceed to Mobile, Ala., and assume charge of the Service at that port. March 4th, 1882. Granted leave of absence for eight days. March 24th, 1882.

Irwin, Fairfax, Assistant Surgeon. Granted leave of absence for seven days. January 18th, 1882.

O'Connor, F. J., Assistant Surgeon. To report to General Superintendent L. S. S., for duty as member of board to examine keepers and crews of the Life Saving Service. January 4th, 1882. Relieved on account of sickness, and directed to report to Surgeon-in-charge, New York, N. Y., for temporary duty. January 18th, 1882. To proceed to Detroit, Mich., and report for duty to the Surgeon-in-charge. February 9th, 1882.

Banks, C. E., Assistant Surgeon. To proceed to Portland, Oregon, and assume charge of the service at that port. March 1st, 1882.

Devan, S. C., Assistant Surgeon. Detailed as recorder Board of Survey—physical examination of officers of the Revenue Marine Service. March 18th, 1882.

Urquhart, F. M., Assistant Surgeon. To report to General Superintendent L. S. S., for duty as member of board to examine keepers and crews of the Life Saving Service. January 18th, 1882.

Kalloch, P. C., Assistant Surgeon. To proceed to New York, N. Y., for temporary duty. January 24th, 1882.

RESIGNATION.

Heberamith, Ernest. Resignation as surgeon accepted, to take effect November 26th, 1881. January 17th, 1882.

PROMOTION.

Smith, Henry, Surgeon. Promoted and appointed surgeon from January 20th, 1882. January 20th, 1882.

APPOINTMENT.

Kalloch, Parker C., M.D., of Pennsylvania, having passed successfully the examination required by the regulations, was appointed an Assistant Surgeon, by the Secretary of the Treasury. January 23d, 1882.

Directory for Nurses.

The following communication explains itself:—

HALL OF THE COLLEGE OF PHYSICIANS,
N. E. Cor. 13th and Locust Sts.,
PHILADELPHIA, April 20th, 1882.

The difficulty of obtaining competent nurses at the moment when sickness or accident makes them necessary is only too well known. Even if a list of nurses be kept, it is impossible to know who is engaged and who disengaged, and hence, not unfrequently, twenty-four or forty-eight hours, or even more, are passed in anxious and fruitless search over all parts of the city before one can be obtained. At the same moment many excellent nurses are idle, who, if known, would be instantly em-

ployed. What is needed is some way to bring the two classes together—a Directory which will keep a list of all the competent nurses, both male and female, who wish to register, with an accurate record of their addresses, qualifications, charges, engagements, etc., so that physicians and the public in Philadelphia and the neighborhood may, at a moment's notice, be able to procure desirable nurses for all classes of patients, either by application in person, or by telephone or telegraph. Such a plan has been in successful operation in Boston, Mass., for the past two years, and is precisely what we need in Philadelphia.

Accordingly, the College of Physicians of Philadelphia has determined to establish such a Directory, open not only to its own members but to the entire medical profession of this city and neighborhood, as well as to the public. The office, with telephone connection No. 2103, will be in the Hall of the College of Physicians, N. E. corner 13th and Locust streets, and will be open on and after May 15th, 1882, at all hours, day or night. Any person desiring a nurse may apply to the Secretary for information and assistance in procuring one. A list of wet-nurses also will be kept, and, if desired, their freedom from any evidences of syphilis or other constitutional diseases will be certified to by a physician, after a careful and minute physical examination. Lists of nurses for the insane, for children, rubbers, companions, etc., will also be kept.

A committee of ladies interested in the success of the enterprise will assist the Committee of the college in conducting the Directory.

The charges will be as follows:—

For Registration (paid only once by nurse)..\$2.00
After Jan. 1st, 1883, this charge will be.. 3.00
For furnishing addresses of disengaged nurses (paid by patient)—
between 7 A.M. and 6 P.M. 1 00
between 6 P.M. and 10 P.M. 2 00
between 10 P.M. and 7 A.M. 3.00
For finding and sending nurse, an additional 1 00
For wet nurses (uncertified)..... 5.00
“ “ (certified after special medical examination).....10.00

All charges must be paid in person or by letter, cash in advance.

When a nurse is ordered by telegraph, the money must be sent by telegraphic money order, in advance.

The success of such an enterprise will depend chiefly on the hearty support of the medical profession. Your attention is therefore called to this matter, and your coöperation is earnestly requested. This can be given best in the following ways:—

1. By sending to the Secretary a list of the names and addresses of all the nurses you can recommend. *Please do this at once.*

2. By inducing all your nurses to register immediately, and

3. By procuring hereafter every nurse you need through the Directory. This last is especially important, as it accustoms both patients and nurses to use the Directory, and teaches them its value. If you wish to get one of your usual nurses through the Directory, it will only be necessary to furnish your patient with a list of

those you desire. The Secretary will refer your patient to any of them that may be disengaged.

Dr. W. W. KEEN,
Dr. ALBERT H. SMITH,
Dr. S. WEIR MITCHELL, } Committee
of the
College of Physicians.

Assisted by Mrs. Theodore Justice, 1824 Wallace street; Mrs. M. Fulton, 26 South 18th street; Miss S. Stevenson, 249 South 13th street; Mrs. S. Weir Mitchell, 1524 Walnut street; Miss Emily Thomas, Secretary, N. E. corner 13th and Locust streets.

Statistics of Consumption.

From the Providence *Journal* we note that the statistics of consumption in Providence, R. I., as given in the last two monthly reports of the City Registrar, shows some very surprising and interesting results. Dividing the population and the decedents from consumption into two classes, American and Foreign, by parentage, the statistics show that in one class a remarkable change in the mortality from the disease has been going on during the past twenty-five years. While the proportion has greatly diminished among the population of American parentage, it has remained nearly stationary among those of foreign parentage, as the following table demonstrates:

POPULATION OF AMERICAN PARENTAGE.

1856—One death from consumption in 268.2.
1865—One death from consumption in 310.1.
1875—One death from consumption in 415.0.
1880—One death from consumption in 435.2.

POPULATION OF FOREIGN PARENTAGE.

1856—One death from consumption in 262.6.
1865—One death from consumption in 248.8.
1875—One death from consumption in 234.4.
1880—One death from consumption in 268.0.

TOTAL POPULATION.

1856—One death from consumption in 266.
1865—One death from consumption in 280.
1875—One death from consumption in 336.
1880—One death from consumption in 326.

From this we note that in regard to the total population there has been a considerable decrease in the ratio of mortality. It would be interesting to inquire into the causes of this diminution of consumption among a portion of the population; and the reasons why this diminution is in one portion of the population and not in the other.

Practice of Medicine in New Mexico.

Through the courtesy of Dr. W. N. Sherman, we have been furnished with a report of "an act passed by the last legislature to regulate the practice of medicine in New Mexico," from which we extract the salient points.

A territorial board of medical examiners is hereby established, which shall be composed of seven practicing physicians of respectability, the three systems of medicine to be represented as follows: Regular physicians, four; homœopaths, two, and eclectics one.

This board shall issue certificates to all who furnish satisfactory proofs of having received diplomas or licenses from legally chartered medical institutions in good standing.

All examinations of persons not graduates or

licentiatees shall be made directly by the board, and the certificates given by a majority of the board shall authorize the possessor to practice medicine and surgery. All certificates must be recorded. The board can refuse certificates to individuals guilty of unprofessional or dishonorable conduct, and may revoke certificates for like causes. Any person practicing medicine without having complied with these requirements shall be punished by a fine not less than \$50 nor more than \$500. The Code of Ethics of the American Medical Association shall be the standard and rule of decision concerning the professional conduct of members of the medical profession. This act became law March 2d, 1882.

Medical Society of the State of Pennsylvania.

It was feared that the recent conflagration at Titusville would materially interfere with the annual session of this body, which is to be held at that place, commencing May 10th.

The Committee of Arrangements announce that they have ample lodging room in private houses to supply all who come, and that the hotels that are left will feed four hundred, if necessary, and feed them well.

The committee are ready to assign good rooms to all the members and those who may accompany them.

An American Work Translated into Italian.

Dr. Louis A. Duhring, of Philadelphia, has received the first part of the Italian translation of his "Treatise on Diseases of the Skin," the translator being Dr. A. Scambellurri, of Naples. The work is there published by Giovanni Irvine. We are glad to make this announcement, from a patriotic standpoint, since it tends to show the fact that American authors are commencing to be appreciated in Europe, and in justice to Professor Duhring, whose magnificent work stands deservedly at the head of the literature of dermatology.

Mount St. Mary's College.

The famous old Catholic College of this name, located near Emmettsburg, Md., has been closed, owing to the outbreak of an epidemic of malignant scarlet fever. More than one hundred and twenty boys were sent to their homes. Two deaths occurred among the students, and while only one other boy had the disease, it was deemed wise to close the college. In the seventy-four years the college has existed, this is the first time it has been visited by contagious disease.

Items.

—Dr. Lewis, a Chicago opponent of vaccination, has died of smallpox.

—Triplet sons, fifty-two years old, and a father 116 years old, are the boast of Robert A. Wright, a mill hand, seventy-one years old, living in Santa Rosa county, Fla.

—A learned Chinese physician, who has traveled much and studied in Europe, expresses his surprise that medicine is regarded as a reputable

profession. In China, it seems, the better classes regard it as humbug and superstition.

—At a French matrimonial agency office: "Oh yes, sir, we have what you want—an orphan of about twenty years of age." "Very good. Is she pretty?" "Not particularly, but she has a fortune of 500,000 f. And, besides, she is consumptive." "Consumptive! Are you quite sure of that?" "Oh, certainly, sir; we guarantee it."

—On March 9th, Mr. Reid's Vivisection Abolition Bill was read for the first time in the British Parliament, and put down for second reading on March 29th. Mr. A. J. Balfour gave notice that on the order for the second reading he will move the following amendment: "That while due provision should be made for preventing the infliction of unnecessary pain on animals, it is inexpedient so to limit scientific investigation as to hinder discoveries which must result in a great diminution of human suffering."

QUERIES AND REPLIES.

A. E. R., San Francisco.—You are right in your interpretation of our editorial of March 11th. By referring to our issue of February 18th, page 192, column 1, you will notice the revised code of ethics as adopted by the New York State Society.

MARRIAGES.

McCARNY—APPLETON.—On April 13th, 1882, at the Haddonfield Baptist Church, by Rev. R. F. Young, Robert H. McCarny, m.d., of Philadelphia, and Miss Mary L., daughter of Samuel Appleton, Esq., of Haddonfield, N. J.

NEVILLE—BROWN.—Wednesday evening, March 23d, 1882, at Chambers Presbyterian Church, by Rev. J. M. P. Otts, W. H. H. Neville, m.d., and Miss Lida T. Brown, daughter of E. D. Brown, al. of Philadelphia.

PALMER—PROUTY.—In Newport, Vt., March 28th by Rev. Henry Fairbanks, Lewis M. Palmer, m.d., of Litchfield, Me., and Nellie B. Prouty, of Newport.

SMITH—POTTER.—At the home of the bride's parents, on Walnut Hills, Cincinnati, O., April 5th, by Rev. S. S. Potter, assisted by Rev. J. G. Monfort, d.d., Samuel L. S. Smith, m.d., of San Angelo, Texas, and Miss Elizabeth Ray Potter.

TURNURE—DIXON.—On Tuesday, April 4th, at Nyack, N. Y., by Rev. P. V. Van Buskirk, Dr. Milton Turnure, of Closter, N. J., and Miss Carrie Dixon, of Nyack.

DEATHS.

ALEXANDER.—On Saturday morning, April 8th, at Princeton, N. J., Archibald Alexander, m.d.

BEADLE.—In Poughkeepsie, N. Y., April 6th, 1882, Edward L. Beadle, m.d., in the 74th year of his age.

JACOBY.—On Thursday, March 30th, 1882, at his residence, 161 Bleecker street, New York, Dr. Moses Jacoby.

MANLY.—On Friday, March 17th, 1882, of whooping cough, Josephine A., daughter of Dr. Thomas H. and Olivia B. Manly, aged nine months.

MASON.—In New York, on Thursday, the 13th inst., at his late residence, Erskine Mason, m.d., aged 46 years.

STILLE.—In New Orleans, La., March 28th, Benjamin Stille, m.d., formerly of Philadelphia.

STUDDIFORD.—On April 15th, 1882, Theodore H. Studdiford, m.d., of Lambertville, N. J., aged forty years.

VAN OSTEN.—In this city, on the 5th instant, Dr. James Van Osten, aged fifty-three years.